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ABSTRACT

The handbook presents six papers dealing with integrating handicapped children into existing early childhood programs. An introductory paper reviews the rationale for mainstreaming, while a second notes such important considerations in mainstreaming as student characteristics, teacher characteristics, and the economics of day care and preschool tuition and transportation. Aspects of the children's experience are discussed in another chapter, with information about preparing children for a special classmate, facilitating interactions, and making classroom adaptations for special needs children. A fourth paper is directed to parents, with suggestions for working with professionals and helping the child's transition into an early childhood program. Implications of special needs in early childhood, including a description of signals of special problems, are addressed in another paper. Discussions of legal aspects and community resources are provided, as well as sample project forms. (CL)

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Toward Integrating Young Handicapped Children

A handbook for preschool teachers, parents, and referring agencies.

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The handbook is based upon the experiences of the PATHWAYS Project at Michigan State University in the Institute for Family and Child Study. During the past several years the project staff has learned tremendously from the teachers and directors of the participating centers, the parents, and the children who have graciously agreed to participate in the project. We especially thank the children and parents for a most rewarding experience, and for all you've helped us learn.

Directors and teachers, we also thank you. The following centers and teachers have participated in the project for the past four years, not only enthusiastically working with children and families, but also willing to do all the paperwork a federal project entails:

GREATER LANSING AREA

(listed alphabetically)

Abbott Nursery School, East Lansing, Michigan (1978-1979)

Director/Teacher: Joan Marble
Teacher: Pam DeNeen

Eastminster Child Development Center, East Lansing, Michigan (1976-1979)

Directors:	Karen Ritts*	
	Bev Osteen*	
Program Coordinator:	Jane Bobay*	
Teachers:	Rick Allen	Steve Kopke
	Lynn Beausoleil	Bill Leavell
	Phyllis Blaha	Colleen Little
	Cindy Carlson	Steve Oakley
	Sue Dunkleberg	Debbie McMartin-Finkel
	Eleanor Hobel	Carol Petty
	Nina Hiel	Barbara Zuckerberg
	Joan Kopke	

* Active on Advisory Council

Laboratory Preschool, Michigan State University, East Lansing, Michigan (1975-1979)

Program Coordinators:	Gayle Clapp	
	Anne Stevenson*	
	Donna Howe (Acting)	
	JoAnn LaVallee (Asst.)	
Teachers:	Katy Allen	Marcia Keifenheim
	Sally Boerner	JoAnn LaVallee
	Colleen Christenson	Chris McKillap
	Bev Faas	Janet Ronk
	Jean Garratt*	Marcia Rysztak
	Sue Godfry	Liz Seelhof
	Meg Griffin	Elaine Villiard
	Nancy Hand	

Married Students Activities Unit Day Care Center, Michigan State University, East Lansing, Michigan (1975-1979)

Program Coordinators:	Suzanne Sullivan	
	Carol Austin (Acting)*	
	Marcia Rysztak (Asst.)	
Teachers:	Carol Austin	Sonja Lewis
	Kay Cummings	Jane McNeil
	Kate Cunningham	Karen Ritts
	Debbie Goldenberg	Robyn Stewart
	Michele Kimmel-Fors	Jan Williams*
	Sally Ledesma	

Spartan Nursery School, Michigan State University, East Lansing, Michigan, (1975-1979)

Program Coordinator:	Donna Howe	
Teachers:	Mariella Aikman	Cheryl Hall
	Cheryl Coates	Bob Page
	Joanne Evers*	Jan Pielemeier
	Carol Fredrickson	Sue Seidman
	Jackie Gardiner	

Sunshine House, Lansing, Michigan, (1979-1979)

Director/Teacher:	Debbie Hubbel
Teacher:	Stephanie Hudson

* Active on Advisory Council

Community Nursery School, Lansing, Michigan (1978-1979)

Director:	Ruth Richardson
Assistant Director/Teacher:	LaVelle Gipson
	Toba Kaplowitz
Teachers:	Karen Kleine
	Viola Spooner

GREATER KALAMAZOO AREA

Canterbury Children's Center, Kalamazoo, Michigan (1978-1979)

Director:	Sally Householder
Teachers:	Sue Grossman
	Irma Johnson
	Linda Johnson

CEYW - Eleanor Miller Day Care, Kalamazoo, Michigan, (1978-1979)

Director:	Dorothy Larsen
Teacher:	Lois Carlson

Comstock Kids Korner, Comstock, Michigan (1978-1979)

Director:	Emma VonZehle
Teacher:	Kathy Rosner

Judson Day Care, Kalamazoo, Michigan (1978-1979)

Director:	Angie Washowski
Teachers:	Judy Dombrowski
	Tina Frye
	Jan Kosino-Littke

Sara Swickard Preschool, Kalamazoo, Michigan (1978-1979)

Director:	Chris Limbocher
Teachers:	Sue Chartier
	Nancy Crowell
	Anne Farmer
	Joyce Nichols

Schoolcraft Community Nursery, Schoolcraft, Michigan (1978-1979)

Teacher: Barb Pschigoda

Westwood Parent Cooperative Nursery School, Kalamazoo, Michigan, (1978-1979)

Teacher: Marie Fredericks

Behind-the-scenes, but very important help was offered to us by the contributing members of the PATHWAYS Advisory Council. Not all contributing members are listed below; they may be listed elsewhere in this section:

Carolyn Au, Parent
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Pam McCourt, Parent
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Mark Sullivan, Office for Young Children
Marlene Young, Teacher

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Thanks also go to the TADS staff (Technical Assistance Development System, Chapel Hill, North Carolina), for their marvelous and enthusiastic assistance to us for three years. Pat Trohanis, Tal Black, and our outside consultants helped make success possible, but our very warmest thanks go to Tanya Suarez and Sonya (Johnston) Prestridge, without whom we would not have been able to finish as successfully. Nick Anastasiow (now in Denver) gave us moral and theoretical support in the very critical beginning stages; being able to remember his guidance helped a great deal.

The PATHWAYS Project Staff used the experiences and feedback from those center staff, parents, children, and others listed to write this handbook. As with our past project endeavors, this handbook has been a cooperative effort. We wish to particularly thank the authors of the various sections who took time from their other PATHWAYS responsibilities to help write this handbook: Sally Atkins-Burnett, Carol Fredrickson, Helene Ginsberg, and Mary Wandschneider. They have done an excellent job and we're very proud to share their contributions with the readers of this handbook. We also wish to thank the other project staff who helped with the handbook: Jean Grof, Donna Howe, and Annette Remsberg.

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PATHWAYS was a dream four years ago--a dream of society not only accepting persons considered to be "handicapped," but also valuing their contribution for what it teaches us about ourselves. We are proud to have been a part of that special dream.

In peace,

Nancy A. Carlson
Mary R. Wandschneider

The editors
Michigan State University
June, 1979

DEDICATION

You cannot choose your battlefields,
The Gods do that for you.
But you can plant your standard
Where a standard never flew.

Nathanial Crane

Although many, many people have contributed to the PATHWAYS project and, by implication, to this handbook, there is one group of individuals whose efforts are and have been outstanding. These superb and dedicated people are called the "PATHWAYS Project Staff." Their efforts on behalf of young handicapped children and their families may never be matched. Their sensitivity, enthusiasm and courageousness has gone beyond what could be called "reasonable effort." If PATHWAYS has been a genuine "human support system," it is only because of the remarkable qualities of the people whose names follow. This handbook is a tribute to these wonderful individuals, and it is to them that this document is dedicated:

Mary Andrews, Evaluation Coordinator, 1976-1979
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Mary Wandschneider, Advocacy and Dissemination Coordinator, 1978-1979

I, personally, am tremendously proud of these people and their accomplishments. It has been a real pleasure to have worked closely with them.

Gratefully,

Nancy A. Carlson

Nancy A. Carlson
PATHWAYS Project Director, 1976-1979

INTRODUCTION

By Mary Wandschneider

The purpose of this handbook is to help those who wish to facilitate the integration of young children considered to be handicapped into existing preschool and day care centers. It is for parents of handicapped children, preschool directors and teachers, and agency people who work with young handicapped children. The materials included in the handbook have been selected from the 1976-1979 experiences of the PATHWAYS Project, based at the Institute for Family and Child Study, Michigan State University.

The PATHWAYS Project has facilitated the integration of young handicapped children into community preschools. The project is based on the following basic assumptions: children come in all sizes and shapes with different strengths and needs; all children need opportunities to communicate, move, play, learn, love and be loved; participation in early childhood programs can provide these important experiences for the young handicapped child. In some cases, the integrated preschool environment has been able to meet the total educational needs of the child. Other children have attended special education programs or received other special education services in addition to their participation in the "normal" preschool setting. By viewing all children as special, the PATHWAYS Project has enabled young, handicapped children to be seen as children first. Emphasis has been placed on strengths and on the common developmental needs of all young children.

The model employed by the PATHWAYS staff assumes that the successful integration of young handicapped children into early childhood programs requires the cooperation and support of many different individuals. There are many participants in this process: the young handicapped child, his or her parents, the other children in the classroom and their parents, the early childhood teacher and center director, special education personnel and other agencies and special services. Each of the participants has his/her own needs and concerns. The PATHWAYS model has responded to those needs by combining the following ingredients to achieve success:

CAREFUL PLACEMENT	+	SUPPORT SERVICES	=	SUCCESS
a match between family's and child's needs and an appropriate classroom is facilitated		staff development ongoing monitoring assessment individual adaptations materials liaison with other agencies case facilitation		child growth parent and teacher satisfaction increased alternatives

The PATHWAYS Project has attempted to facilitate integration through several basic approaches: (a) accepting referrals from community resources, (b) evaluating children and family needs, (c) providing careful placement into a classroom by matching a child's needs and skills with an appropriate program and classroom, and (d) providing support services to teachers and parents, e.g.: developing liaisons among agencies helping the child, aiding in assessing children and developing individual educational plans for them, increasing teacher skills through workshops, reading materials, etc. Our perceptions of the critical ingredients for successful integration/mainstreaming are reflected in the materials included in this handbook.

The following outline describes the various parts of the handbook.

PART I. INTEGRATION - HOW TO DO IT SUCCESSFULLY

Section A: INTEGRATING YOUNG HANDICAPPED CHILDREN INTO THE WORLD OF EARLY CHILDHOOD. General description of integration/mainstreaming, questions, answers and suggestions. *Of interest to all groups.*

Section B: PLACING YOUNG HANDICAPPED CHILDREN INTO REGULAR PRESCHOOL PROGRAMS: IMPORTANT CONSIDERATIONS. Important considerations in placing young handicapped children into regular preschool programs. Includes information on characteristics of children and of teachers who may successfully participate in the integration process. *Of interest to all groups.*

Also contains an introduction to child care, guidelines for choosing child care, and economic aids to integration. *Of interest to parents and referring agencies.*

Section C: THE CHILDREN'S EXPERIENCE: HELPING HANDICAPPED AND NON-HANDICAPPED CHILDREN LEARN TOGETHER. Information about how to help handicapped and non-handicapped children learn together. Contains curriculum ideas for regularly enrolled children learning about special needs, and classroom adaptations for special children. Also contains annotated bibliographies of books that can supplement the integration experience, including stories about children with special needs to be read with all children. *Of particular interest to teachers.*

Section D: FOR AND ABOUT PARENTS OF YOUNG HANDICAPPED CHILDREN IN THE MAINSTREAM. Description of the effects upon the family of having a handicapped child. Also some considerations in aid of parents and professionals working together, including information on how parents can help their special child's transition into an early childhood program. Contains an annotated bibliography on both topics. *Of use to all groups.*

PART II. REFERENCES AND SUPPORTIVE MATERIALS

Section A: INDIVIDUAL DIFFERENCES: INDICATIONS AND DEFINITIONS OF SPECIAL NEEDS IN EARLY CHILDHOOD. Information on indications and definitions of special needs in early childhood, as well as a brief overview of "normal" child development. *Of use to all groups using the handbook.*

Section B: WHAT YOU CAN EXPECT FROM THE SCHOOL DISTRICT. Information about the special education system: laws, services and procedures, preprimary special education programs, support services available to private preschools from the Intermediate School District, and an annotated bibliography on laws and legal rights of children. *Of use to all groups.*

Section C: COMMUNITY RESOURCES. Listings of community resources which provide supportive services to handicapped children, their families and agencies working with handicapped children. *Of use to all groups.*

Section D: GLOSSARY OF TERMS. A glossary of terms frequently used in reference to handicapping conditions, and services to handicapped children. *Of use to all groups.*

See next page.

Section E: ARTICLES AND FORMS FOR INTEGRATION. Articles and specific forms to use in integrating young handicapped children. *Articles may be of interest to teachers, center directors, aides, volunteers, parents and referring agency people. Forms may be of particular use to programs integrating preschool handicapped children.*

INTEGRATING YOUNG HANDICAPPED CHILDREN INTO THE WORLD OF EARLY CHILDHOOD

An Introduction to Integration/Mainstreaming

by Helene Ginsberg

Young children have an enormous capacity for learning, experiencing, playing. Watching a group of 3, 4- and 5-year-olds at play in a nursery school or day care center, one is impressed by many things. Children's vitality and curiosity are apparent as we observe their play--their imagination and passionate devotion to the moment can also be seen. One of the most profound aspects of early childhood is the openness of young children, their simple acceptance of variety and their trust in the adults among them to offer a model of reality.

Increasingly, observing nursery schools and day care centers, one finds a great variety of children. Families of varied economic and cultural backgrounds are making use of child care programs. Looking closer, one may also find variety in the developmental characteristics of the children. Some may be "handicapped," but they fit so well; it seems so natural and sensible that these children should be playing and learning alongside "non-handicapped" friends. Although it may not be obvious at first, one may notice a little boy with leg braces having a tea party in the dramatic play corner, a young girl with hearing aids playing "Wonder Woman."

This natural and sensible mixture of children represents a popular but controversial educational movement - the "mainstreaming" or integration of "handicapped" children with special needs into regular educational programs with "non-handicapped" children. As a result of recent federal legislation (Public Law 94-142 - The Education of All Handicapped Children Act of 1975), public schools are required to provide a free and appropriate education to all children who experience handicaps, wherever possible in the "least restrictive" or most normalized classroom setting.

Some preschool programs, outside the domain of public education, have for many years accepted children with special needs and problems, on an individualized basis. Now this practice is receiving greater public attention, in light of new laws and attitudes which support the inclusion of handicapped individuals into all aspects of daily living. Integration into regular preschool programs is now seen as a possible and beneficial educational alternative for many young handicapped children. As the prejudices, barriers, stigma and obstacles facing handicapped individuals are one by one overcome, many parents and public school teachers are logically asking - "why not start <u>before</u> negative attitudes develop?" Indeed, why not utilize the natural openness of young children to help develop a strong foundation of early developmental skills and self esteem for the young handicapped child.

Underlying the movement to integrate or mainstream early childhood programs are values which indicate that all children are special, unique and different while they also have certain common needs for affection, communication, skill mastery and human interaction. In other words, handicapped children are "more alike than different." Ideally, the mainstreamed preschool classroom allows for <u>all</u> children to be appreciated for their individual needs and differences. Hopefully this will foster full development while each child learns that a disability is but one aspect of a person's life. Successful mainstreaming in early childhood implies that the preschool environment is flexible and challenging enough to offer growth-producing stimulation to children with varying needs. The early childhood teacher is seen

as knowledgeable about the needs of young children, and one who can mobilize his or her existing skills in teaching and guiding young children to serve children with special or different needs.

In addition to advantages for the handicapped child, mainstreaming/integrating the young handicapped child into a community preschool has benefits for the "typical" children, parents and teachers. All these groups can grow from the experience by learning to understand and accept "differentness." Children can learn that, although a particular person has limitations, that person can still learn, grow, and be a friend. Teachers can learn new skills related to adapting and individualizing their programs, which may carry over to their planning for all children. Parents can learn - through the flexibility of the children - how to accept, instead of exclude, the person who is different in some way.

It is clear that mainstreaming can be justified from many viewpoints - legal, moral, socio-cultural and educational. For the young handicapped child, the mainstreamed environment is really a part of a continuum of services, including more specialized services such as therapies, instructional modes, settings, and equipment which pertain to his/her individual disability. It is an alternative, along with the more traditional special education and therapeutic options. It is an alternative which is feasible and meaningful for all concerned. Like any alternative, it should be carefully considered in view of individual children's needs and the needs of their families.

The successful integration of young handicapped children into existing early childhood programs requires the participation and cooperation of many different individuals: the young handicapped child, his or her parents, the early childhood teacher, the other children in the early childhood program, their parents, and specialized teachers and agencies concerned with the handicapped child. The successful integration is based on the consideration of the needs of these many different people. The handicapped child, in order to grow and develop in an optimal fashion, will need to be placed in an early childhood setting which meets his or her needs, and where he or she will be more like other children than different. His or her parent(s) will need to stay involved in the child's program, and become a part of the regular activities for parents provided by the center. The early childhood teacher will need information, support and opportunity to participate in decision making. Other children will need information, care and facilitation so that they can come to know the handicapped child as a person. They will need a fair share of their teacher's time and attention. Parents of non-handicapped children will need to know that their child will benefit from learning and playing with a handicapped child and that their child's needs will continue to be understood and addressed. Personnel from other educational and medical programs involved with the handicapped child and his or her family will need to be kept informed of the child's progress and be included in decision making.

By understanding and addressing these complex and varied needs, mainstreaming of young handicapped children can be a positive and growth producing experience. It can result in the full development of the handicapped child - as a whole person. It can also result in the development of more responsive and effective early childhood programs which are better able to meet the needs of all young children. Yet the key ingredients - careful placement, support services which meet the needs of all participants, and cooperation among different individuals - are all essential. Mainstreaming is a realistic ideal - we must all work together to continue to make it happen!

PLACING YOUNG HANDICAPPED CHILDREN INTO REGULAR PRESCHOOL PROGRAMS: IMPORTANT CONSIDERATIONS

by Mary Wandschneider
Helene Ginsberg
Carol Fredrickson

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PLACING YOUNG HANDICAPPED CHILDREN INTO REGULAR PRESCHOOL PROGRAMS: IMPORTANT CONSIDERATIONS

by Mary Wandschneider
Helene Ginsberg
Carol Fredrickson

There are a number of important considerations to weigh before placing a young handicapped child into a regular preschool program. First, is the child a likely candidate for integration? What kind of program does that child need and how can the program be evaluated? Within these programs, what are the characteristics of teachers who are likely to be successful in serving children with special needs? Finally, what are the available economic aids to integration? The following sections are meant to provide information to help answer those questions.

The Young Special Child: A Likely Candidate for Integration? What to Look For

Many young children with special needs can become active participants in a regular nursery school or day care center. The experience of being with non-handicapped children in a varied, child-oriented setting can open numerous opportunities for early development. It is important to carefully consider the characteristics and needs of the child to determine whether or not an integrated experience would be beneficial at this point in time.

Given the wide developmental variations among young children with handicapping conditions, there is no precise formula for determining which children are most likely to succeed in an integrated setting. Rather, one must assess different qualities and characteristics of the child in order to form an overall picture. In weighing the different factors, it may become apparent that although an individual child may benefit from an integrated placement, such a placement is not feasible. Some children have predominant needs for specialized therapies not readily accessible; the demands placed on other young handicapped children sometimes do not allow them enough energy to be able to additionally participate in an integrated setting. For these children, integration may remain a future option.

Once it has been carefully and jointly determined with parents that a child could most likely benefit from an integrated placement, consideration must be given to available programs. Those of us who work with young handicapped children must be creative and assertive in exploring programs and arranging placements. At the same time, the need for supportive services must be considered.

In making these decisions, the following characteristics of the child should be considered:

Developmental level - At what developmental age does the child function? Are the majority of his/her skills at the one-, two-, three-, four- or five-year-old level?

Severity of handicap, safety needs, needs for attention - Will the child need an extra person in the classroom to assist in moving him/her

from one activity to the next? To what extent does the handicapping condition interfere with the child's total, overall functioning? Can therapy needs be adequately met through special education or community services and yet allow adequate time for preschool participation?

Physical and verbal imitative skills - If a child has strong imitative skills, it is likely that an integrated setting, where appropriate and functional behavior is modeled continuously, would be at least as appropriate as a segregated setting where peer models may not be as skilled. Also, language and communication skills are often good indicators of a potentially successful experience.

Absence or presence of severe aggressive or acting-out behaviors - A child who manifests multiple and moderate to severe aggressive tendencies would be most appropriately placed in a setting where most of the children have learned to channel their anger. In this type of setting, children who are angry and frustrated (a natural developmental emotion) will learn non-physical means of modifying/controlling aggression. Also consider--to what degree can the child control him/herself? To what extent will this be manageable in a regular setting?

Needs for limits/structure - Some children have a difficult time coping with changes in their environment. For these children, the school setting might provide a needed predictable environment: where limits are consistently enforced, where lunch is served at about the same time each day, where activities follow in the same daily sequence. It's important to also consider to what extent can the child follow simple directions given both individually and to the group? How much structure is needed by the child?

Experience with peers - The quality and type of experiences a child has previously had with children of his/her age or developmental level will offer clues regarding potential for successful integration into similar settings. Currently, is the child isolated, or does he/she come frequently and consistently into contact with non-handicapped children at home, in the neighborhood, at church or synagogue?

Anticipated needs for adaptations - A classroom which would require a minimum number of adaptations is sought. However, some adaptations beyond normal individualization of instruction may be necessary. Will adaptations be compatible with the ongoing program? (See curriculum section, Part A, Section III, in this handbook.)

Anticipated need for additional staff support - Can the child function relatively independently in a group setting? The child who requires full time one-to-one supervision is not yet ready for the integrated setting. On the other hand, some children only require extra attention at very specific times (negotiating stairs, at transitions, etc.) and this can be provided in many preschool settings.

Independent activity - Can the child initiate play activities on his/her own? Can the child play independently for short periods? This would be expected in a regular preschool setting.

Size - Is the child about the same size as other children of a similar developmental level? This may be an important factor.

By viewing all these factors, a child's readiness for integration can be assessed. A visit to observe a potential preschool program will give valuable information about what skills a handicapped child might need in order to adapt to that setting. A visit for the child and parents to the integrated preschool setting will provide additional information on the potential for such a placement. (See "Guidelines for Choosing Child Care" later in this section.)

Characteristics of Teachers Who Are Likely Candidates to Integrate Handicapped Children Into Their Classroom

In addition to evaluating whether a child is a likely candidate for integration, it is critical to determine whether the regular classroom teacher is also a likely candidate. In fact, experience with the PATHWAYS Project at Michigan State University has led us to believe that successful integration hinges on *teacher willingness and readiness.* Some of the particularly helpful characteristics exhibited by teachers indicating readiness are:

--Willingness to risk, to learn
--Tolerance for differences from the "norm"
--Coping abilities - ability to interact with a variety of people, ability to be flexible
--Proficiency at handling children's behaviors, maintaining order/peace while reinforcing self-concept of children
--Organization - planning diverse and challenging activities with group, while keeping the needs of individuals in mind
--Ability to observe and differentiate atypical behavior
--Ability to provide individualized attention/educational experiences
--Willingness to conduct/maintain assessment process
--Ability to establish and maintain rapport with parents

The degree of a teacher's competence in each of these areas may be ascertained by asking the center director and the teachers themselves how each teacher may be described in reference to these characteristics. The resulting combined description gives an indication of: the types of children and families with whom the teacher would feel most comfortable, the needs which can easily be met by the teacher, and where added support might be needed.

An Introduction to Child Care Programs

In each community there are different types of child care programs available. The following terms all refer to organized group learning and care experiences for children under 6 years of age: "preschool program," "early childhood program," "child development center," "child care center," "child care program," "day care," and "nursery school." However, there is great variation among and between different types of programs for young children: day care, nursery school and parent cooperative nursery school. Head Start, Title I and Montessori programs are not described. This information is intended to provide general information and to highlight some of the major differences and similarities between these three different program types.

Program Description

Day Care	Nursery School	Parent Cooperative
Full or half day program usually for children ages 2½-5 years. Day care is designed to provide a full day's experience including meals, nap/rest, personal hygiene, dressing, as well as small and large group learning and play experiences. Mainly used by parents with work or study schedules.	A shortened group experience which includes small and large group learning and play, outdoor or large muscle activities, singing/music and arts. A small snack is served. Children attend primarily for an enrichment experience, to learn to get along with other children. Mostly for 3, 4, 5 year olds. Sometimes only for 4 and 5 year olds.	Very similar to nursery school setting with a major difference - parent participation! Parents must assist in the classroom on a rotating basis and share in the running and maintaining of the program. Mostly for 3, 4, 5 year olds. Sometimes only for 4, 5 year olds.

Size

All three of these types of programs vary in size and numbers of children. Most programs have at least 15-20 children and may have as many as 25-30 children. Some centers have only one group or class, others may have multiple groups.

Hours		
Generally 7:00 or 7:30 a.m. to 5:30 or 6:00 M-F. Some centers offer a choice of full day or half day schedules. There is usually a minimum of hours the child must be enrolled--e.g., at least 5 hours/week.	Usually 2 or 2½ hours a day--generally 9:00 a.m. -11:30 a.m. or 1:00-3:30 p.m. Some centers offer morning programs only. Program varies from 2 days to 5 days/week.	Generally the same variations as nursery school.
Enrollment Times		
Usually continuous throughout the year. Some centers have waiting lists.	Usually enrollments are made during the spring or summer before the fall term.	Same as regular nursery schools.
Yearly Calendar		
Usually year round, including summers, with brief seasonal, national, and religious holidays. Follows the work calendar.	Usually only runs fall, winter, spring according to public school calendar (same vacations).	Same as regular nursery schools.

Teaching Staff

The qualifications and experiences of teaching staff in early childhood programs vary a great deal. You must check with each program to determine the competency of staff, how many teachers and how many aides, inservice training that is available, etc.

Day Care	Nursery School	Parent Cooperative
Fees		
Typical ranges for day care are: $7.75-9.00/day for full-day program or $4.25-5.00/day for half-day program. Some day care centers offer discounts for more than one child from same family. There may be an enrollment fee, and a charge to maintain the child's place over vacations. Most day care centers can receive reimbursement for eligible families from the department of Social Services (DSS).	Nursery school fees vary--generally around $40/month for 2 days/week; $50/month for 3 days/week and $70/month for 5 days/week. There may be an enrollment fee.	Generally less than regular nursery schools (i.e., $25/month for 2 days, etc.).
	Licensed nursery schools and parent cooperatives may receive reimbursements from DSS for eligible clients if they fulfill DSS requirements. Check with individual programs about this. Also, some programs may have scholarships available.	

Major Program Components

The following are program components which may appear in any of the three types of early childhood programs:

Free play - A choice situation in which many activities or learning centers are available to children who may move at their own initiative throughout the room. Includes a balance of dramatic play, creative media, small and large muscle activities, construction toys, language and preacademic experiences.

Small group - A more structured period in which the group of children is divided into small units to work with an adult on such tasks as counting, matching, talking about pictures, writing names, etc. Is not always preacademic, but this may be expected.

Clean up - Children are expected to put away materials after using them, attend to disorder and cooperatively restore the room to order with the teacher's help. Usually designates end of free play time.

Large muscle/outdoor time - Structured or free choice use of indoor or outdoor equipment (slides, balance beams) or directed activities such as creative movement, dancing, marching, group games.

Snacks/meals - Nutritious snacks or meals employed with emphasis on serving, passing and self feeding. Also a quieter time to relax and socialize in small groups.

Nap/rest - Opportunity for rest or sleep on individual cots, mats or blankets. In some centers all children must nap, others have provision for nappers and resters. Typically found only in full time day care program.

Washing/toileting - Scheduled times for washing hands and using bathroom. Bathroom use also encouraged throughout the day. Emphasis on independent self care.

Licensing of child care programs - In Michigan, as in many other states, the state Department of Social Services licenses and regulates all three types of child care programs under the heading of "child care centers." In order to be licensed, a program must meet various criteria regarding: safety of the building, fire codes, sufficient space per child, staffing procedures, food storage, nutritional standards, curriculum and program components, equipment and other administrative and programmatic concerns. The Michigan Department of Social Services is granted authority to license child care programs under P.A. 116 (1973). The regulations accompanying this body of law also describe specific qualifications regarding child care programs. Each county has day care licensing consultants who are responsible for licensing and regulating local child care programs.

Guidelines for Choosing a Child Care Program

Fees, as described earlier, charged by child care programs vary somewhat, but are within a close range. Programs and buildings, however, differ greatly. The following are some ideas to help you select the best program for a particular child.

Step 1: Pick 3 or 4 centers that are convenient and telephone the director to see: whether there are vacancies, whether they are open the hours and days that you need care, and what ages of children they take.

Step 2: Meet with the director or head teacher to discuss the center's program. Here are some questions you might want to ask:

--Who is the main person responsible and how much experience has s/he had?
--How many children is each teacher responsible for? 6? 7? 10?
--Is parent participation encouraged? How much is required?
--Who makes major policy decisions?
--Are the children grouped by age, interest area or ability?
--What is the center's health policy? How does the staff handle giving medication to children?
--Is there a tested emergency plan and does every staff member know that plan?
--Are naps required or optional?
--What are the fees? When must they be paid?
--Is toilet training required?
--Is transportation provided?
--Is the center licensed?
--What hours and days is the center open?

Step 3: Take time to observe the program while children are there. The morning between 9:00 and 11:30 is a good time. Look for:

--Warm, smiling adults who talk and play with the children. (Adults should not be grouped together in one place.)
--A variety of activities for children to choose: blocks, wheel toys, climbers, sand or water, clay, paints, puzzles, pegboards, books, paper with crayons, pencils and scissors.
--Methods of discipline with which you agree.

--Children who seem happy, involved.
--Teachers that smile at you and make you feel welcome.
--A building that is clean and safe. (Is the outside play area fenced in? Are dangerous items kept out of children's reach?)

WARNING SIGNALS!!!

--A center that does not encourage parents to observe or visit.
--Teachers who are physically rough and abusive with the children.
--A building that is dirty and/or unsafe.
--More than 30 children in one classroom.
--Children made to sit and wait for as long as 10 or 15 minutes for an activity.
--Children who move about without guidance or involvement for 30 minutes or more.
--Teachers that ignore or seem apathetic toward the children.

Adapted from the child care choosing guides of:

The Office for Young Children, 403 West Greenlawn, Lansing, Michigan, 48910, and

Child Care Coordinating and Referral Service, 1024 Hill Street, Ann Arbor, Michigan, 48104.

The Economics of Day Care and Preschool Tuition and Transportation

Tuition to a preschool program can be expensive, and transportation is rarely provided; therefore, the following is included in order to describe potential sources that may be able to provide for tuition and transportation.

Tuition

A potential source of tuition and transportation support for the integration of handicapped preschool children into day care centers and preschool programs is the Department of Social Services (DSS). The information that follows also applies to family day care homes. However, in order for a family to be eligible for this financial support, particular requirements, as noted in the following guidelines, must be met:

1. The Department of Social Services will provide day care or preschool tuition support for any preschool child in a family that is currently receiving Social Services income and meets one or more of the following criteria:

   a. The parent(s) are employed or are in training for employment.

   b. The parent(s) are attending school.

   c. There is a social, emotional, or medical health need of either the parent(s) or the child, and it has been determined that a day care or preschool placement for the child will help to alleviate or eliminate this problem. In such cases, documentation regarding the potential value of the day care or preschool placement by a physician, psychiatrist, psychologist, day care center director, caseworker, etc., is required.

d. There is a Protective Services referral.

If the family is a two-parent family, both parents must fulfill criteria (a) or (b).

2. The Department of Social Services will provide day care or preschool tuition support for a preschool child in a family that is not currently receiving Social Services income if the family meets low-income eligibility guidelines. A sliding fee scale has been established and the amount that a particular family would pay is based on current income level. This category generally applies to single-parent families only; however, it also applies to two-parent families if one parent is incapacitated and receiving General Assistance or Medicaid. Once again, the family must meet one or more of the eligibility requirements listed in (a), (b), (c) and (d) of criteria #1 above.

Day care or preschool tuition rates are established by the Department of Social Services and are paid directly to the day care center or preschool program that is providing care for the child. In order to receive DSS reimbursement, the center must be licensed by the state Department of Social Services and must have established an agreement to purchase service with DSS. An authorization letter detailing the daily rate is then received by the center, along with a letter authorizing payment for each particular child.

To investigate this financial option more completely, contact the Day Care Division of the Department of Social Services at 373-6751 in Ingham County or 385-1130 in Kalamazoo County. If you do not reside in Kalamazoo or Ingham counties, check the telephone listing through the particular county in which you do reside (under Social Services). There is an alphabetical distribution of clients among DSS day care workers and a family will be referred to the worker handling that particular part of the alphabet.

Transportation

The Department of Social Services can partially reimburse a day care center or preschool program that provides transportation to those children determined eligible by the guidelines listed previously. Most programs do not provide transportation, however. In general, DSS will pay for transportation only if the parent is unable to provide it him/herself, or if transportation schedules conflict with the parent's work schedule; for example, in the case of kindergarten children who attend a day care center. The current (Summer, 1979) DSS transportation rate is $1.25 one way.

Special Education through the school district will provide transportation to or from (but not both) a private preschool program for children who are identified as handicapped by the school system in the following situation:

If a child is in a special education program he/she may be provided transportation to (or from) that program from (or to) a private preschool when the cost of transportation is less than to his/her home. In other words, the most that can be provided to a private center is transportation one way.

In addition to Special Education, the following organizations in the Greater Lansing Area provide transportation for handicapped persons and may be able to assist in transportation to and from preschool:

--Varsity Cab
--Easter Seal Society
--Spec Tran
--Volunteer Action Corps.

See Table 1 on the following page for details on their services.

Table 1
Transportation Options for Handicapped Persons in the Greater Lansing Area

Eligibility by Geographical Area	Regular Arrangements? (e.g., 2 mornings weekly 2-way)	2-6-Year-Old Alone? Safety Measures	Cost and Times
VARSITY CAB - 332-2551 -Only residents of East Lansing eligible -Ride must start or end in East Lansing, but can go throughout tri-county (Ingham, Eaton, Clinton)	-Yes (must bring child to bus) -Not equipped for wheel chairs	-Probably--if can sit alone/will have to check liability insurance -Cab with seat belts	-$1.60 1st mile, $1.00 each mile after. East Lansing pays ½ of price, not to exceed cost of $30 monthly -Available all day
EASTER SEAL - 394-5700 -Throughout tri-county	-Yes (must bring child to bus)	-Yes (serves "dependent mobility deficient") -Car or van with seat belts	-Negotiable cost -Available all day
SPEC TRAN - 394-6230 -People living in City of Lansing and others: Delta (Lansing Mall), Meridian, Haslett, Okemos, Delhi/Lansing Township eligible. Does not provide to: St. Johns, Eaton Rapids, Diamondale, Mason, Williamston.	-Yes (must bring child to bus)	-Do transport children, normally parents travel with kids -½-size bus - no seat belts	50¢ one way -2 vehicles only, so not always available -M-F 6:30 a.m.-9:00 p.m., Sat. 10-5 available -Must fill out application, call to obtain one
VOLUNTEER ACTION CORPS - 353-6663 -Ingham County only	-No, not available on regular basis -Not equipped for wheel chairs -One-two day advance notice required	-Could transport kids alone -Van with seat belts	-No charge -Available daily 9:00 a.m.-6:00 p.m.

THE CHILDREN'S EXPERIENCE: HELPING HANDICAPPED AND NON-HANDICAPPED CHILDREN LEARN TOGETHER

by Helene Ginsberg

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Sharing Information About Differences/Disabilities with Children

Young children react in a variety of ways when they encounter another child who acts, moves, looks, speaks or thinks differently than they do. Because young children are still learning the "rules" of life, they are often strict conformists in their ideas of what is acceptable and what is unacceptable. Young children generalize about the rest of the world from their own experience. Therefore, they are keenly aware of differences in other children. They are curious about those differences and try to explain disabilities in terms of what they already know.

Interestingly, often young children are also very open in their attitudes about physical and developmental differences. Since they usually have not learned negative social attitudes towards handicaps (this typically occurs after attaining school age), they do not automatically reject a child on the basis of a disability characteristic. Young children are amazingly open to the social models portrayed by adults and are thus able to learn positive attitudes towards disability, especially when a positive model is provided through the adults' actions, words, behavior and explanations.

It is surprising to note the different kinds of reactions that young children display when meeting and relating to a handicapped child. The imagination and curiosity that children bring to the task of understanding handicaps is a thrilling process to observe. Below are listed some of the typical kinds of reactions to disability observed in young children in integrated settings:

A. Identification with the handicapped child:
   - "When I was a baby I had only one finger" - in reference to a classmate born with only one finger on each hand.
   - A child takes two long blocks and uses them as crutches.
   - A child goes home and asks parents for a helmet, just like the one worn by a brain injured classmate.

B. Creating Explanations for handicaps:
   - "Tommy is still a baby" - in reference to a three-year-old classmate who does not walk yet.
   - "He didn't eat enough carrots" - one child to another while talking about a classmate with cerebral palsy.
   - "When Sally grows up she's gonna hear real well."

C. Fears about own intactness:
   - "Will I catch it?" (often not expressed verbally but through avoidance of touching special child.)
   - In dramatic play, "My arm's gonna get chopped off."

D. Recognition/observation of special characteristics:
   - Children talk about and name the differences they notice in another child.
   - With younger, preverbal children, they may simply point (to hearing aids or braces for instance).

E. Acceptance:
   - Delighting in special child's achievements ("Look - Kenny is smiling!")
   - Choosing special child to play with, to share with, to sit next to.

In responding to children's reactions and questions, it is most important to understand the child's own thought process. The following ideas are offered as possible ways to positively share information about differences/disabilities with young children:

1. Know as much as possible about a particular disability or characteristic. The more you know, the more you will be able to provide accurate, precise information to children and parents. (See Annotated Bibliography at the end of this section.)

2. Listen to children's questions. Before answering, be sure you understand what it is they want to know. You may have to clarify the question to be sure you understand. (ex: child - "How come Timmy is still a baby?" adult - "You mean, 'How come Timmy can't walk yet?'")

3. Answer children's questions in children's terms. It's just like talking about sex with young children. Often we, as adults, have so many feelings and ideas mixed up with the topic that we overdo it in responding to children's questions. Try to give short, precise and clear answers, in language that children understand. Also, try to find out what the child thinks the answer is and work from there to expand his/her understanding. Don't give more information than the child asks for. Give him/her time to assimilate what is said.

4. Remember children's "magic" and egocentric thinking processes. They are trying to make sense of a new and unfamiliar piece of information about a human being. In so doing, they try to relate handicapment to their own experiences, directives from parents, and fears/fantasies about their own intactness. Avoid using misleading language ("her ears are broken"). Be alert to what is behind children's questions. Be sure to reassure children about the causes of impairment when they seem to be concerned. ("That's how Tami was born. She didn't do anything wrong, it's just how she was born.") Use simple language and phrases that can stick in their minds. Remember, you will probably have to answer the same questions many times in the beginning. (It is not unusual to find children repeating your simple explanation to peers or parents.)

5. Answer by giving children the opportunity to feel for themselves what it's like to not hear or see very well, to use a wheelchair, etc. (see curriculum ideas listed later in this section). A demonstration can be more effective sometimes than an explanation.

Although you want to promote honesty, remind children to be aware of the special child's feelings. Sometimes questions can be repeated and repeated, long after the need for information has passed. When questions about a child's physical or developmental differences are repeatedly asked in that child's presence, some redirection by adults is needed. Remind children about the special child's feelings, try to relate that to the children's own experiences. ("How would you feel if Tony kept asking you about your red hair?")

Preparing Children for a Special Classmate

Teachers often ask, "Should I tell the children that a handicapped child is coming into our group? What should I tell them before the special child comes?" These are sensitive and legitimate questions which teachers of young children must consider. Central to these questions is the goal of achieving the fullest possible participation and acceptance of the special child within the regular classroom.

There are no clearcut criteria about whether or not to prepare a group of children for a new child with special needs. There are, however, some things you might want to consider in your planning:

1. What is your typical process for bringing a new child into an existing group? Do you alert the children beforehand? Generally follow the same process with the special child.
2. What experiences has your group already had with special children? Can you anticipate what their reactions might be? If this is the first experience with a special child, it might be helpful to wait until the child comes to visit - your information will be more <u>real</u> once they have met the child.
3. With older groups of children, prior discussion of obvious handicaps (hearing impairment, visual impairment, physical disability) is more meaningful than with younger children. Older children will be able to discuss more abstract concepts and relate these ideas to their own, wider experiences. Wherever possible, when discussing special needs that are outside of the children's actual experiences, use pictures, photographs or simulations (simulations are approximations of the situation).
4. What are the characteristics of the special child? Some labels of impairment only have significance in terms of adult diagnosis and educational planning and are neither apparent nor significant in terms of children's awareness. Learning problems, physical and cognitive/developmental delays, for example, are not very visible to other children. It really is not helpful to draw unnecessary attention to these developmental differences. Often too, even with more clinically noticeable impairments, the special child's own personality, sociability, enthusiasm and playfulness is more predominant than the "handicapping" condition. Consider whether additional information about the special child would enhance or detract from his acceptance by the group.
5. Sometimes a special child has obvious physical characteristics which <u>might</u> frighten or "turn off" other children (for example - facial disfigurement, no legs). In these cases, you want to prepare children beforehand so that they may be alert to the <u>person</u>, the child who exists within this very different body. By using pictures, simulations and stories, you are introducing information to the children so that they will be able to be more positive during their first encounter with the special child. Be sure to convey your own excitement and good feelings about the child as a person.
6. Sometimes it is better to discuss a new special child informally, with small groups of children during a relaxed time. Rather than an announcement during large group, the one-to-one approach is much more natural and easier for the children to understand.

7. Whatever your plans for preparing the group for a special child, be sure you have a chance to discuss those plans with parents. The parents of the special child will often be concerned about other children's reactions, the parents of typical children will be curious also. Parents, in many cases, may also be able to give you valuable tips on what has worked before in helping their particular child to become comfortable in a group.

3. GUIDELINES FOR FACILITATING INTERACTIONS

The goal is interaction - kids learning from and being with other kids. Children provide one another with language models, models of appropriate social behavior and novel ideas for interacting with materials. Children also provide infectious curiosity, enthusiasm, and caring. Children are at one another's level both physically for eye contact and visible speech models, and in terms of interest and sense of humor. As adults we can promote the interaction of other children with the special child. Interaction which is beneficial is based on acceptance, experiences and response (feedback). What follows are guidelines for promoting interaction:

1. Set a "normalized" model - treat the child as any other group member. Greet him, show affection and interest, involve him matter of factly in the daily routine. Let other children see that you value this child just as you value them.

2. Have the same expectations (wherever feasible) and set the same limits for the handicapped child. Be careful not to pity the child or allow inappropriate behavior. Expectations and limits should be high enough so that a special child does not always succeed. (No one does. It's called learning.)

3. Model effective communication skills: maintain eye contact, get the attention of the child through naming objects, etc.

4. Promote direct contact with child - redirect children's questions and comments to the actual child and serve as a moderator.

5. Highlight special skills and interests of the child, and cue parents so they can support these positive images. Be alert to what other children see as special; e.g., helmet, riding on special bus.

6. Model courage and honesty in talking about differences among children. Differences are valuable in our society. Don't pretend that everyone is the same.

7. Divide your time equally among children. Children "hungry" for attention are usually those who "scapegoat" or pick on other children. Do not give undue attention to the special child. Try to work with the handicapped child and another child, instead of always one-to-one with the handicapped child.

8. Remember, everyone does not need to love the special child; some children may quite naturally not become friends with him or her. This is fine; neither the child nor the parents should feel pressured to particularly like the special child because of his/her impairment.

9. Be alert to typical children's positive or negative over-reaction to the special child. Care must be taken to understand the sources of the over-reaction. Over-reactions may take the following forms: mothering, overwhelming, attention, aggression, name calling, extreme exclusion, etc. Try to spend some non-judgmental, individual extra time with the child who over-reacts to a handicapped classmate. Sometimes the child has gathered incorrect information, or has received pressure from parents, or has had some previous negative, associated experience.

Curriculum Ideas for Young Children: Learning About Special Needs

Young children, in their curiosity about life, people and the environment, are open to information and attitudes about their own special needs, and the needs of others. In your daily planning for children, it is possible to incorporate activities and experiences which provide needed information about handicaps and opportunities for children to explore related feelings and attitudes. Teachers involved in the PATHWAYS Project have shown enormous creativity in developing curriculum about special needs. We'd like to share with you some of these ideas. Needless to say, the oft-repeated statement - "Please feel free to adapt and change this activity to the needs and abilities of your group..." holds true for these ideas.

1. Simulations (approximations of a situation or experience): Children learn by doing (don't we all!). The experience of a handicapping condition can profoundly affect a child's understanding of a classmate. It is helpful to begin simulation experiences with a short discussion which highlights the key concepts of the experience, as well as questions you want the children to consider. For example, when simulating blindness, prepare children by talking about the act of seeing ("What do we use our eyes for? What are some things you see?") Discuss common experiences of sightlessness (night, power failure, eyes closed), and what it is like when you can't see, "What are the other ways you can know what is around you?", etc. Then prepare the children for the experience that is to come, by describing what you will be doing. Ask them to be aware that things may sound or feel different. A wrap-up discussion following the experience will help the children to verbalize and recall what they felt, saw, heard, and learned. It is also a time to direct children's thinking to the feelings and needs of people who regularly experience a similar situation, What follows are some common and easily understood simulations:

   Sight: Blindfolding/blind-walk. In small groups, divide children into pairs. One child in each pair is chosen to be blindfolded. Use a dark, soft kerchief, a scarf, or a length of fabric as a blindfold. The other child in the pair will be the guide. Choose a familiar route (indoors or outdoors) and instruct the guides to give their partners directions. Children may walk holding hands or with arms linked. Later, have the children switch roles. Have blindfolds available for individual use at other times. Also, try a blind snack, with one side of the table blindfolded, the other not. A few young children may react negatively to the "blindfold." Ask them to instead close their eyes, or perhaps use a darkened room with no windows.

   Hearing: Simply have children cover their ears with their hands. Or try talking to them with a pillow over your mouth. Talk about what it feels like to not hear another person. Talk about what they can do, even when they cannot hear.

   Splinting: It is possible to splint different parts of the body so that children can experience more limited use of joints and limbs. Fingers can be taped together to simulate the experience of having fewer or no fingers on the hand. Encourage children to perform familiar activities (washing hands, drawing, catching a ball, etc.), in the splinted positions. Use wide, non-allergenic tape or old sheets cut into strips, heavy cardboard in a long strip or light, thin strips of sanded wood for splints.

Wheelchairs and Crutches: These are easily experienced by young children. Try to extend the experience by having a child spend the whole freeplay period in a wheelchair, not just a few minutes. Also, having adaptive equipment (such as child sized crutches) in your dramatic play corner, presents a message that this is part of life. It also provides the children with a chance to act out in play.

2. Stories/Books: Reading aloud is an excellent vehicle for sharing ideas and information. The Annotated Children's Bibliography at the end of this section lists many books at a child's level which discuss handicapping conditions. Often books about sensitive issues (divorce, death, handicaps), are more fully explored in smaller groups.

   Adapting Stories: Unfortunately, there are not many books which portray children with special needs in everyday situations. You can extend the use of flannel board stories simply by adapting pictures of characters to show them with a handicapping characteristic. It does not have to become part of the story, but why can't one of the three bears wear a hearing aid? Perhaps Curious George could wear leg braces.

   Picture Files: Be on the lookout for photographs and drawings of people, young and old, with special needs. Add these to your picture files and use them on walls, in collages, etc. Look for positive images of competency and adequacy, as a positive role model for special and typical children alike!

3. Learning About the Senses, Learning About the Body:

   Ears: Large size models of the human ear are available from Departments of Speech and Audiology, Speech and Hearing Clinic (MSU), etc. The structure of the ear is fascinating and can open up discussion about ear care, hearing impairment and hearing testing.

   Eyes: Models of the eye are available from similar sources. Also, use of sunglasses and different color transparent and translucent films can bring attention to sight and prompt discussion of how our eyes work, how to care for our eyes, what eyeglasses do and what a visual impairment is.

4. Guided Discussions: Often, early childhood programs have a "large group" or "get-together" time for show and tell, introducing concepts, activities, and group stories or discussion. This time can be used with older children as an opportunity for talking about special needs. Drawing on the children's own experiences, and using pictures, puppets, props or flannelboard figures as aids, these can be times of sensitive and meaningful thinking and sharing. Some ideas for such open discussions are:

   Feelings: Different kinds of feelings--what causes feelings? how do you feel when _____? what can you do when you feel ____? how do you know what someone is feeling? How do feelings get hurt?

   Communicating Without Words: How do we talk without words? How do you show how you are feeling without talking? What are different ways of communicating?

   How we Look and Who we are: Everyone looks different; sometimes how we look changes; how is each person different? How are they the same? If they wear a different hat are they still the same person? If they didn't have a leg would they still be the same person?

What would you do if_____?: Prompting children to imagine what they would do and feel under a variety of circumstances (if the sky turned green, if your dog talked, if there was no teacher at nursery school) can also include conditions related to handicaps (what if you didn't have legs? What if you couldn't hear? What if you could only use one hand?, etc.)

5. Community Helpers: The Adult Handicapper as Classroom Visitor: The visit into a preschool classroom of an adult who experiences a handicap can be a thrilling experience. Such a visit offers children and teachers a chance to be with and talk to a grown up, competent, special person who can share his/her experiences. Like visits from other community helpers, adult handicappers can talk about themselves, their disability, any special equipment they use and other interesting things about themselves (what they like to do, members of their family, etc.). They can also encourage children to ask questions, touch them, etc.

Adult handicappers can also participate in your classroom in a more low key fashion - playing, singing and eating with children, responding to their questions and comments. This kind of participation provides an excellent model for positive self esteem for the special child as well as further positive imagery for other young children. Children get the message - "We all live here, we all are important and valuable."

Most likely you will have to make a special effort to seek out adult handicappers. Our society is just beginning to respond to the rights of handicapped citizens regarding full participation in employment, social and recreational activities. Unless you have adult friends with handicapping conditions, you will probably have to contact one or more of the associations, agencies or organizations serving the handicapped. Local handicapper advocacy groups such as the Center of Handicapper Affairs (Lansing), the local Association for Retarded Citizens, the local Speech and Hearing Center are possible resources. Also, local offices of Vocational Rehabilitation, and the United Cerebral Palsy Association are possible contacts. Often Special Education teachers and administrators know of adult handicappers who would be delighted to share their experiences with young children. TV stations may have interpreters for the deaf to contact as a source of information.

As with other visitors to your classroom, a little preparation is helpful. Prepare the children as you would for any visitor. Then prepare for the particular visitor in the following ways. First consider if your room or building has any physical barriers which would inconvenience or bar a wheelchair user or physically disabled person. Also consider if transportation might be a problem with which you or a class parent can assist. If possible, plan to meet with your visitor(s) beforehand, preferably in your classroom, so that you can give them an idea of the children's level of attention and understanding. This is a good time to go over how visitor(s) will participate, what information or presentation they are planning, what materials, equipment or space they will need. Also, use this time to prepare visitor(s) for the possible reactions of your children, and discuss different ways of responding to children's often blunt, spontaneous and uninhibited questions. If it is not possible to meet beforehand, definitely use a phone conversation for these same purposes. By being honest and open about your own feelings, and in dealing respectfully with a visiting adult handicapper resource person - you can jointly create a positive experience. Be sure to follow up with a thank you note, children's drawings and feedback on children's reactions after the visit.

6. Sign Language...a Beautiful Language: Manual communication is a beautifully expressive language. Children have a special facility for learning new languages, as well as a unique responsivesness to nonverbal "body language." Sign language can thus be incorporated into many activities, especially songs, finger plays, and story telling. Children's books are available (see Bibliography) which show the hand positions needed to tell the story. Why not teach the fingerspelling signs for the alphabet when teaching the ABC song? As you learn new signs, you'll find many ways to adapt them for classroom use. You'll be amazed at how eagerly children begin to use them, too!

Responding to Individual Needs: Classroom Adaptations for Speical Children

Children who experience handicaps are first and foremost children. The activities and approaches that are beneficial for all young children will also be appropriate for young children with special needs. In addition, there are some special considerations to keep in mind which will assist the child in participating as fully as possible in classroom activities and events.

Try to discover a way for each child to experience every activity that she/he wishes to try. Enlist the children's aid in problem-solving how to adapt a particular activity (children are usually better divergent thinkers than adults). If the child fails, accept it as you would the failure of any child who was reaching too far beyond s hig grasp. Nice try! All children deserve the right to try even if the all-knowing adult fears they will fail.

The suggestions included in this section are general guidelines. They may help you initially to get to know the individual child and to give other classroom participants information about the child's needs. However, all children are unique and different - by getting to know them, learning from their parents and their other teachers and therapists - you will discover their own actual needs.

Many of these suggestions were taken from the Project Head Start Series: Mainstreaming Preschoolers (see Bibliography for further reference).

I CAN'T HEAR YOU: SUGGESTIONS FOR HEARING IMPAIRED CHILDREN

Compiled by Barbara D. Siebens, published by MAED

1. The child must see your face well. If he is small, get down to his level. If he is older, try to be within distance for reading newspaper headlines and where he need not crane his neck or see your face only from the side or below.
2. Have a good light on your face whenever possible. Do not have the child looking into the light. Not only do you become an empty silhouette but it is very tiring for his eyes.
3. Get the child's attention before you expect him to understand what you are saying or even that you are talking to him.
4. Stand still when you talk. Do not turn your face away or cover your mouth. No one can speechread a moving blur or the back of a head.
5. Speak naturally as you would to anyone. Do not exaggerate. Rephrase if the child does not understand rather than repeat the same words over and over.
6. Take time to explain things. Give content clues - a written word if he is older, an object or picture if at hand, a familiar reference - to set the stage or to help follow change of subject.
7. The child's hearing aid should be working well at all times! Do not yell. Speak naturally and clearly and his aid will do the amplifying. Even with the best aid, however, he will not hear normally and you can never guess what or how he hears. You can only insure that the best sound possible gets to him.
8. Be aware of the acoustic environment. The hearing aid amplifies ALL sounds and some may blot out speech.
9. Give him security. He may need to be shown, or to be the second or third rather than the first to be asked to perform.
10. Be open about his handicap. You, he, and anyone around who is significantly involved all know that he is hearing impaired and might as well act accordingly.
11. Encourage and support him but do not spoil him. He does not need the handicap of being a brat in addition to his hearing impairment.
12. Keep your sense of humor and help the child develop his. Have fun and include him in the fun.
13. Be flexible - relax!
14. Extra batteries and cords should always be available for hearing aid maintenance.

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I CAN'T SEE YOU: SUGGESTIONS FOR VISUALLY IMPAIRED CHILDREN

Compiled by Gloria Anderson and Carol Rottman

1. Use sound to help the child. Your voice leads and directs a young child within the environment. Get his attention before giving instructions. Describe where you are and how the child can get to you with clear directions and in a normal speaking voice.
2. Consider available light source. Light can be distracting for some paritally sighted children, but for others, indirect lighting may be inadequate.
3. In a group setting, call the child by name if you expect a response from him. Gestures are not always enough.
4. Sound is important for mobility. A moving speaker can confuse a child's ability to find his way.
5. Speak naturally when you talk. Use words that are in the child's vocabulary, but don't be afraid to use words that refer to seeing. However, the words "here" and "there" are too general for descriptive use. Be specific and label objects that give direction and location.
6. Explain everything that is happening around the child. Give the sources of sounds and smells. Describe with variety, quality, and richness!
7. Eye conditions sometimes require attention. A child needs to learn how to care and maintain his own special visual aids or prosthesis.
8. Make the sound environment meaningful for the visually impaired child. Eliminate confusing or self-stimulating sound fields. The sorting of sounds is a difficult skill which takes time, experience and explanations to develop.
9. Build a child's self-confidence by letting him try. Take him through an activity or game a couple of times before he must do it on his own. Remember that imitation is a visual skill.
10. Talk about blindness. A child needs to be comfortable with himself. As a teacher, you need to be comfortable with the concept of blindness and to help his peers to understand the way he will learn about the world.
11. Encourage independence. Let the child do for himself. Dressing, eating, toileting and playing are all part of his daily living. Independence and competence depend on your ability to give him the encouragement and time to do it for himself.
12. Learning to laugh and enjoy all experiences is important in the total development of a visually impaired child. His sense of humor is part of him. Help it develop!

SUGGESTIONS FOR WORKING WITH EMOTIONALLY IMPAIRED CHILDREN

1. Help to build the child's self concept by enabling the child to experience many successes in varied activities and by letting the child know that he or she is valued for his or her own self.

2. Think positively about the child. All children have strengths, these abilities are the best place for you to begin.

3. Provide a secure routine. Children with emotional/behavioral problems are often struggling to make sense of a confused image of reality. By providing a consistent, orderly and secure daily routine you will be helping the child feel safe, comfortable and more able to participate.

4. Plan transition times carefully. Transitions are frequently very difficult for disturbed children - misbehavior is often the result of confusion about what is expected. Gently warn children of changes ahead of time - letting them know they have five more minutes to play will give them time to adjust to the change.

5. Setting limits helps children to control their behavior. Be fair in establishing your classroom limits and then be <u>consistent</u> - let children know what you expect of them and follow through on consequences of inappropriate behavior. Be sure you have clearly stated and demonstrated the behavioral limits to children and adults alike.

6. Use physical contact: to ensure the safety of the child and of those around him or her; to provide support, guidance and encouragement; and to teach a disturbed child by "moving them through" new activities. Be sure to approach the child in a non-threatening way.

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SUGGESTIONS FOR WORKING WITH PRESCHOOLERS WITH SPEECH AND LANGUAGE DIFFICULTIES

1. Help the children feel secure and comfortable - they'll enjoy talking! Children feel secure and become more fluent and experimental when they are asked to perform at their level, and when they are praised and valued for their attempts at speech. Let them know that any attempt they make at talking is appreciated but try not to overreact to a quiet child's attempts - this may cause a negative reaction (e.g., further and sustained silence).

2. Listen! Listen! Children can be helped to develop speech and language when adults stop, listen seriously to what they are saying, and respond. Learn to interpret children's difficult speech - often parents can help you with this. Nothing is more frustrating for a child with a speech problem than people saying "What? What did you say?"

3. Help other children understand - be a translator. In the beginning, you may have to translate to help other youngsters learn to understand a child who has a speech problem. After a little time, the other children may be helping you!

4. Encourage children to talk! Talk with children while they are involved in an activity. Invite children to bring special things from home to talk about. Encourage (by asking) children to talk about their feelings. Ask parents to let you know when something special happens at home so that you can incorporate that into your conversation. Polaroid pictures can be helpful in stimulating the child's conversation at home about activities that happen at school and vice versa.

5. Ask open ended questions rather than yes-no questions. "What did you do in the playground?" will give the child more opportunity to verbalize than, "Did you go down the slide?"

6. Language is a living tool - children learn language as the result of experience. Use words, ask questions and give children an opportunity to use the new words and concepts. Associate new words and concepts with concrete experiences.

7. Receptive language develops before expressive language or "input comes before output." Feed children's receptive language by talking about what you are doing, describing the environment, sounds, sensations, etc. Use language that stretches the child's understanding just a little. Be explicit, direct and descriptive in your language.

8. Expand on what children say - if a child says "me do it" - expand it by saying "Susie, you're doing a dance." Let the child know that you understand and model a more adult way of expression, a more complex way of thinking.

9. Talk at the appropriate language level - use sentences that are just a little longer than the child's sentences. Don't confuse a child who uses primarily one and two word sentences by speaking in paragraphs.

10. When working with children who have problems articulating sounds correctly - be a good articulation model yourself. Get the child's attention, have him/her watch your face and speak clearly. Children can improve their articulation by imitating an adult. When a child mispronounces a word, repeat the word correctly. It will take many times of hearing a repetition for the child to correct him or herself.

11. With children who stutter, try to slow down your own speech rate. This will help the child relax and will also present a good model for the child to follow. This is more effective than telling the child to slow down. Let the child know you will listen patiently and don't draw attention to the child's disfluency. Look at the child; do not turn away.

THE CHILD WITH SPECIAL HEALTH PROBLEMS: SOME SUGGESTIONS

1. Ask the child's parents for accurate information on the child's needs, abilites, and limitations. Some children with special heatlh problems have restrictions on their activities, others do not - don't assume a child should be restricted unless you are specifically told so. You could make up a list of activities that typify your program and review these with parents, the child's physician or therapists.

2. Work out emergency procedures when the child enrolls - make a visible chart so that in case of an emergency, adults in the classroom can act promptly and efficiently. Otherwise, do not anticipate crises or use undue caution with the child.

3. If the child takes medication - use careful procedures for labeling, storing, and dispensing the medication. Keep accurate records. Watch for changes in a child's activity level, attention span or coordination and let parents know immediately about these changes. Changes in behavior may indicate a need for modification in the dosage or type of medication - your observations will assist the physician in adjusting medications. Make it a practice to routinely ask about possible side effects which may accompany the medication.

4. Health impaired children may need to "do it themselves" even more than other children in your program. Children with health problems have often been overprotected, sometimes because of required hospitalization or confinement. This may have interfered with the child's ability to develop a feeling of mastery and competence. Encourage independence and self-help.

5. A health impaired child may need chances to rest throughout the day. Alternating between active and quiet activities will help a child to pace him or herself. A child who lacks stamina just needs more opportunities to rest, but he or she need not be restricted from doing, mastering and accomplishing.

6. Children who have chronic health problems, who have been hospitalized and treated by many doctors may have greater than usual childhood fears about doctors, hospitals and separation from parents. This is a normal reaction to the unpredictable, invasive and often emergency nature of their past medical experiences. By having "doctor" and "hospital" props (bandages, stethoscopes, syringes, white coats, etc.) available in the dramatic play corner of your classroom, you can give this child an opportunity to act out and gain power over traumatic incidents.

7. Children who have had lengthy confinements at home or in the hospital will need practice relating to other children. Having missed out on experiences with other children, they will need to learn to share, take turns, cooperate and play in groups. It may be difficult for a child with these types of prior experiences to learn to interact positively with other children, but it is not impossible.

8. Epilepsy or seizure disorder is a kind of health problem. A child can have a seizure in your classroom, even if he or she is on anti-convulsant medication. You can insure the child's safety and keep everyone (including yourself) calm through this sometimes frightening event by remembering:

    1. You cannot stop the seizure. Do not attempt to do so. Clear away any furniture the child may bang into, try to make the place where the child is soft and safe by supplying a mat or pillow.

2. Do not put anything in the child's mouth in order to pry it open - this can damage the teeth and jaw. The child will not swallow his/her tongue. If the child's mouth is open - you can insert something soft like a rolled up handkerchief to keep him/her from biting his tongue.

3. Call parents/physician immediately if child has trouble breathing or if seizure does not end or if the child has one seizure after another.

4. Allow child to rest afterwards.

5. Record time of seizure, duration and any and all preceding events for the parents'/physician's information.

6. Reassure other children and try to engage them in activity with another adult while you stay near the child. It can be very frightening to come out of a seizure and be surrounded by a ring of upset classmates.

7. Following the seizure, reassure the other children again (and probably again) that everything is OK. Having a seizure is something that occasionally happens to some people. While it is (or may be) frightening when it occurs, when it is over, things return to "normal." The child who had the seizure is not hurt by the event; in fact, in most cases the child will not be able to remember that it occurred.

I CAN DO IT TOO: HELPING THE LEARNING DISABLED CHILD LEARN

1. Make it Simple: Help the child with learning problems by keeping directions short, simple and clear. Get the child's attention before you begin. Show children how to do an activity by physically guiding them through and letting them "get the feel of it." Reduce clutter and noise for children who are distractible or who have poor discrimination skills. To begin with, use visual materials that are simple, high contrast and show few items.

2. Make it Short: Children who are easily distracted or very active have a hard time sitting and listening. Short, successful periods of learning are better than long "struggles." With a very young child, "short" may mean from 1-3 minutes at first.

3. Organize the Environment: A structured, stable routine in an organized physical environment will allow the child to function more successfully. Be sure activities have a clear beginning, middle and end. Follow the same routine daily and teach the children to know "what comes next."

4. Teach Concepts: Children with learning disabilities often lack basic information about colors, shapes, directions, etc. They need to be taught these skills in isolation since they won't just pick them up from the environment. Over time, try different teaching approaches; use demonstrations (show them, don't just tell them), give lots of opportunities to practice.

5. Use the Other Senses: Children may not be getting clear messages from one sensory mode and need to have information coming in through different sensory modes. If you are giving verbal directions also use pictures or gestures. If a child is working on a visual/motor task - add texture or weight to supplement the processing of information. Use different presentation modes until you find ones that work.

6. Break Down Tasks into Easy Steps: When teaching a new skill or presenting an activity, think through all the smaller steps that are included in the larger whole. Have the child achieve success at each of the smaller steps, in sequence, building up to completion of the whole task.

7. Although success is important, help the child to develop mechanisms to cope with failure. Adults sometimes do not point out that there are various activities in life that none of us can do yet. While a modicum of successful experiences are important for the self concept of the child with learning problems, so also are strategies for coping with failure or inability to accomplish something at a particular point in time. The coping strategies must be those the child can employ on his own without your help.

WORKING WITH CHILDREN WITH ORTHOPEDIC HANDICAPS

1. Remember - the child is a whole person, not just an arm or leg that doesn't work well. Although a child's physical differences may be more apparent and obvious, try to focus your attention on the child - a unique individual with personality, tastes, and unique experiences.

2. Positioning - Many children with physical handicaps need to be in comfortable and well balanced positions in order to participate and learn. A child who feels unsteady or uncomfortable will not be able to participate actively. Look for positions which will allow for maximum freedom to see or be a part of the activity and to move arms and legs. If sitting or standing, does the child need to be supported? Get information from the child's parents and/or physical therapist about his or her positioning needs.

3. Modifications - You may have to make physical adaptations in your classroom to accomodate the child's needs. Try to anticipate whether the child will need more room for his wheel chair to fit, blocks to raise up equipment, etc. As the child becomes a part of your program, adaptations that are needed will become more evident. The child's parent will be a good resource.

4. Encourage Independence - Children who are physically handicapped are already dependent on others for some of their mobility needs. Although it may take more time, encourage children to move on their own. Decide when it is necessary to lift or carry a child and be consistent about it. Some children may need to be carried outdoors for instance, or lifted onto the toilet. But the child may also be able to move from one place to another given enough time and encouragement from others.

5. Special Equipment - Does the child use braces, wheelchair, walker, prosthetic arm or leg? If so, find out how this equipment works, how to place the child into and out of the equipment. Have parents demonstrate the use of these devices so you are comfortable with their use.

6. Toileting - Physically impaired children who lack sensation or mobility below the waist will need assistance toileting or may need diapering. Consider this beforehand and try to make arrangements so that toileting can be managed with dignity. You will need to establish a verbal or signal system so that the child can inform you when he or she needs to go to the bathroom. Try to create an experience that is as much as possible like the experience for other children (e.g., don't hide the child away from others as if something were "wrong").

7. Give the Child a Chance! - There are many things that a physically handicapped child can do and will strive to do. You may be surprised - be delighted when your preconceived notions are proven wrong. Give the child time and lots of encouragement. It's well worth it for both of you.

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MORE TIME TO GROW: WORKING WITH MENTALLY RETARDED PRESCHOOLERS

1. Structure activities so that the child feels sucessful. Break the tasks down into as many small steps as needed for success.
2. Praise progress, no matter how small. This will motivate the child to do more!
3. Try to be positive about failures - praise a child for trying then go back a few steps to where the child can succeed!
4. Be patient, it may be necessary to show a child a skill or activity <u>many</u> times before he or she learns it.
5. Be tender, loving and accepting but <u>not pitying</u>.
6. Don't talk about a child's problems in front of him or her. Children know when they are being talked about.
7. Concentrate on a child's strengths, not his weaknesses.
8. Be consistent in your expectations of the child's behavior. Follow through when a child does not meet these expectations.
9. Make the child responsible for a part of the classroom routine, and praise his or her reliability. (Can hand out cups and napkins at snack, tell children it's time to come inside, etc.)
10. Never allow other children to make fun of child because of things he or she can't do yet.
11. Include each child as fully as possible in all activities. Being left out hurts.
12. Give each child an opportunity to show off a little, such as displaying a drawing. When a child is proud of something - show it to others.
13. Developmentally delayed children need help learning in the following ways:
    1. <u>Taking in information</u> - through their senses and through varied activities.
    2. <u>Processing information</u> - using comparison, cause and effect, and memory skills
    3. <u>Using information</u> - applying information results in new motor and verbal responses.
14. Have high expectations of the child! Don't set limits on achievement because of a label given to a child.

BIBLIOGRAPHY

Childrens' Books: An annotated bibliography of books for young children about special needs and individual differences.

Resources have been organized under the following general headings:

Adoption

Death, Separation and Loss

Developmental Delay

Divorce

Feelings

Hearing Impairment

Individual Differences

Relationships

Physical Impairments

Transition Into a New Program

Visual Impairments

Compiled by Helene Ginsberg, Molly Frederick and the PATHWAYS Staff

ADOPTION

Bunin, Catherine and Sherry, Is That Your Sister?, New York, Pantheon Books, 1976.

This true story is told by Catherine, a 6-year-old adopted child. In the rather long text, she explains her adoption and that of her little sister, Carla. The book is illustrated with black and white photographs of Catherine and her family. A good source for teaching the older child about adoption. Ages 5 and up

Lapsley, Susan, I Am Adopted, New York, Bradbury Press, 1974, $4.95.

A very general text, told by Charles, an adopted child. It would be a good starting point for a parent beginning to talk with their child about adoption. There is no mention of where the child originates from, but the book could possibly produce thought-provoking questions by children. Ages 2½-4 years

Meredith, Judith, And Now We Are a Family, New York, Beacon Press, 1971.

This is a book about adoption written as though a mother is talking to her child. The book deals with many aspects of adoption, from the original parents to the actual adoption. While the text is well done, the child-like printing and drawings are overplayed. Ages 3 and up.

DEATH, SEPARATION AND LOSS

Fassler, Joan, My Grandpa Died Today, New York, Behavioral Publications, Inc., 1971.

A boy's granfather dies and he experiences the emotions surrounding death (sadness and mourning) for the first time. The story deals with the boy's own way of coping with the loss. Unusual sketches illustrate the text. Ages 4½ and up

Mack, Nancy, I'm Not Going, Milwaukee, Raintree Editions, 1976.

A very realistic story telling about the ambivalant feelings a boy has when told his family is moving to Baltimore. Large color photographs do a good job of expressing the feelings of anger, frustration, and finally acceptance of the situation. Ages 4 and up

Stein, Sara Bonnett, About Dying, New York, Walker and Co., 1974.

This excellent book was written to help both the parents and children in understanding and coping with death. There is a large printed story text for children, along with full page black and white photographs. To the side is an explanation for parents of anxieties and emotions their child might be feeling. A superb book for both parents and children. Ages 3½ and up

Viorst, Judith, The Tenth Good Thing About Barney, New York: McClelland and Stewart, Ltd., 1971.

This is a very beautiful story about a little boy whose cat dies. There is a funeral for the cat and the boy's mother tells him to think of ten good things to say about the cat at the burial. He only can think of nine until a talk with his father reveals the 10th reason, the most touching one of all. This is an excellent book to aid in teaching a young child about death. Ages 3 and up

Zolotow, Charlotte, My Grandson Lew, New York, Harper and Row, 1974.

This is about a little boy, Lewis, who suddenly wakes up and wants to see his grandfather, who had died when the boy was two. His mother is amazed, as he has never asked for him before. Many feelings about death are honestly and simply expressed by Lew and his mother. Soft, colorful drawings well illustrate this book. Ages 3 and up

DEVELOPMENTAL DELAY

Fassler, Joan, One Little Girl, New York, Behavioral Publications, Inc., 1969.

Laurie is considered a "slow" child, but she is also the first child to notice the new fallen snow or a small flower. It makes her feel bad when adults say she is slow. She becomes a much happier child when the adults around her take the emphasis off the things she can't do well and put it on the things she can. Very pretty drawings illustrate this thoughtful book. Ages 4 and up

Klein, Gerda, The Blue Rose, New York, Lawrence Hill and Company, 1974.

Jenny is a mentally retarded child. This beautifully written book compares her to a blue rose, something that is "rare and different and beautiful." The text, accompanied by photographs of Jenny, is successful in making mental retardation more understandable and real to the reader. Ages 4 and up

Fassler, Joan, Don't Worry Dear, New York, Behavioral Publications, Inc., 1971. $6.95.

Jenny is a late bloomer who still sucks her thumb and wets her bed. Through the support of her family she outgrows all of these habits--on her own. A wonderful story for any child, especially one who has a similar problem(s). Ages 3 and up

Kraus, Robert, Leo, the Late Bloomer, New York, Windmill Books, Inc., 1971.

A delightful story about Leo, a tiger who is a late starter. While the father anxiously waits for Leo to bloom, the mother tells him a "watched bloomer doesn't bloom." Eventually Leo does bloom and has something to say about it--"I made it!" Large colorful drawings illustrate the text well. Ages 2½-5

Lasker, Joe, He's My Brother, Chicago, Albert Whitman & Co., 1974.

This story, told by his brother, is about Jamie, a child with a learning disability. His disability is never mentioned in the text, only that he is slower than other children. The story deals with what Jamie is and isn't able to do. Written in a factual tone, this book would be best read to an individual or small group of children so a discussion could easily follow. Ages 3½-5

Sobel, Harriet Langsam, My Brother Steven is Retarded, New York, MacMillan Publishing Co., 1977.

A young girl tells her mixed feelings toward her mentally retarded brother, Steven. The text is clearly and honestly written. The book is illustrated by black and white photographs. Ages 3½ and up

Wikland, Ilon, I Can Help Too, New York, Random House, 1974, $1.95.

This is a simple story told mainly with pictures of all the things a small child is able to do. A good book for the child who feels (or is made to feel) that s/he is too little to do anything. The book has cardboard pages and colorful drawings. Ages 2-3½ years

DIVORCE

Berger, Terry, A Friend Can Help, Milwaukee, Advanced Learning Concepts, Inc., 1974.

This is about a girl whose parents have separated and how grateful she is to have a close friend to talk out her feelings with. Large, color photographs do an excellent job of displaying the emotions she is feeling. Ages 4 & up

Berger, Terry, How Does it Feel When Your Parents Get Divorced?, New York, Jullian Messner, 1977.

This book deals very explicitly with the issue of divorce from the child's point of view. Based on an actual child's experiences, the feelings expressed are open and honest. Black and white photographs illustrate the text.
At least 5 years and up

Cain, Barbara S. and Elissa P. Benedek, What Would You Do? A Child's Book About Divorce, Indianapolis, Youth Publications, 1976.

Bright, colorful drawings illustrate this book of a child's feelings concerning his parent's divorce. The book was written with the help of children in a question/answer type format. The positive aspects (ex., no more arguments) of a divorce are displayed as well as the painful side. Ages 4 and up

FEELINGS

Berger, Terry, I Have Feelings, New York, Human Sciences Press, 1971.

A beautiful book on different types of feelings, both positive and negative. Each feeling is accompanied by a situation which helps bring it into context for the child. An excellent book for bringing out a child's own feelings.
Ages 4½ and up

Dunn, Phoebe, Tris and Judy, Feelings, Mankato (Minn.) Creative Educational Society, Inc., 1971.

Each page of this book tells about a different emotion. The text deals with how a child feels as a result of these emotions. The photographs are extremely well done and appropriate. Ages 2½ and up

Mack, Nancy, Why Me? Milwaukee, Raintree Editions, 1976.

This is a book that probably every child could identify with. Short tales "written" by children about common situations they encounter in life problems, such as being chosen last, and being dropped to the lowest reading group, are discussed. Ages 5 and up

Miles, Betty, Around and Around - Love, New York, Alfred A. Knopf, 1975.

Simple and direct, the photographs say more than words ever could. Even so, the text is short and says so much in teaching a child about the feelings and emotions behind love ("you can't grab it or take it; when you give it, you make it"). A wonderful book for any age child!

Simon, Norma, I Was So Mad, Chicago, Albert Whitman & Co., 1974.

This book, "written" by children, tells of things and situations that make them angry. The situations discussed are very real; children will find them easy to relate to . The text is illustrated with rather amusing and appropriate drawings. Ages 3 and up

Sinberg, Janet, Divorce is a Grown-up Problem, Avon Books, New York, 1978.

A very simple and sensitive clarification of divorce as a problem between parents. It also reflects the mixed feelings that young children have when their parents separate - in terms that children understand. A good introduction written for parents highlights the key issues that children experience.
Ages 3-5

Wittels, Harriet & Joan Greisman, Things I Hate, New York; Behavioral Publications, Inc., 1973, $6.95.

Written in verse, a boy tells about things he dislikes in his life; such as shopping with his mother and going to bed early. He then goes on to remember that these same events that he hates have a positive side to them as well.
Ages 3½ and up

HEARING IMPAIRMENT

Levine, Edna, Lisa and Her Soundless World, New York, Human Sciences Press, 1974.

The main emphasis in this story about Lisa, a deaf child, is on her learning to communicate through use of a hearing aid, sign language, lip reading and therapy. Written in a matter-of-fact manner, this is a book a child could easily relate to, for the author tries to put the reader in Lisa's place.

Litchfield, Ada B., A Button in Her Ear, Albert Whitman & Co., 1976.

Young Angela tells how her hearing loss was detected and how her hearing aid helps her to hear. The different professionals involved are depicted as caring adults. Angela is shown explaining to her classmates what that "button" in her ear really is. Delightfully illustrated. Ages 4-6

Peter, Diana, Claire and Emma, New York, The John Day Co., 1976.

This is a true story about two deaf sisters Claire and Emma. Written by their mother, the text deals with many of their unique experiences such as their therapy for learning to lip read and their hearing aids. The text is illustrated by large color photographs of the children and their mother. Ages 3 and up

Peterson, Jeanne Whitehouse, I have a Sister. My Sister is Deaf, New York, Harper and Row, 1977, $4.95.

This story is told by a little girl about her deaf sister. There is emphasis on what she can do (such as her keen sense of touch) rather than on her disability. Written in poetic form, it is beautifully illustrated with black and white drawings. Ages 4 and up

Roy, Howard L., Cars and Trucks and Things, Washington, D.C., Gallaudet College Press, 1974.

Written with words and sign language pictures, this "beginner book" names and describes different types of vehicles a young child comes in contact with, such as bicycles, trucks, cars and buses. It also tells about the people who operate them. The sign language pictures are clear and easy to follow. Ages 2-3

INDIVIDUAL DIFFERENCES

Accepting Individual Differences: Developmental Learning Materials, 7440 Natchez Avenue, Niles, Illinois, 60648.

This is a series of learning materials designed to help children accept developmental differences among people. Four oversized books, each with large color photographs, discuss visual impairment, hearing impairments, mental retardation (Amy Can Learn) and motor impairment (I Knew I Could Do It!). There is an accompanying guide for each book to aid teachers in presenting the material.

Brightman, Alan, Like Me, Boston, Little, Brown, & Co., 1976.

This story is "told" in verse by a mentally retarded child. There is a stress on his similarities to other children. There is also emphasis on the fact "retarded" is just a word - "When they call me retarded, that word is all they see" - and shouldn't act as a label. Vivid color photographs illustrate the text. Ages 3½ and up

Stein, Sara Bonnett, About Handicaps, New York, Walker & Co., 1974.

A beautiful book about handicapper and a child's reactions to them. The book is illustrated with large black and white photographs. There are two texts - a large print one for children and a small print one for helping parents deal with feelings their child might have about handicappers. An excellent book for all ages!

Walton, Darwin, What Color Are You? Chicago, Johnson Publishing Co., 1973.

The first half of this book is rather technical for a small child, but the second half is worth sharing. It deals with likenesses in people though their skin color varies. Color photographs illustrate the text.
Ages 3 and up

PHYSICAL IMPAIRMENTS

Fanshawe, Elizabeth, Rachel, London, The Bodley Head Ltd,, 1975.

Rachel is a young wheelchair user. The story stresses all she is able to do and the "normality" of her life. Colorful drawings illustrate the text. Ages 3 & up

Fassler, Joan, Howie Helps Himself, Chicago, Albert Whitman & Co., 1975.

This is the story of Howie, a child who experiences Cerebral Palsy. The story deals with his similarities to other children as well as his differences. Howie wants very much to help himself and finally he finds a way. The drawings that accompany the text are excellent and illustrate the text well. Age 4 & up

Mack, Nancy, Tracy, Milwaukee, Raintree Publishers, Ltds., 1976.

This book looks at the life of Tracy, a child who experiences Cerebral Palsy and is a wheelchair user. Written in the first person, the book deals with activities Tracy can do, the therapy she undergoes, and the equipment she uses to aid her in getting around. And she does get around! Color and black and white photographs help in telling the story. Ages 3 and up

RELATIONSHIPS

Barkin, Carol & Elizabeth James, Are we Still Best Friends? Milwaukee, Advanced Learning Concepts, Inc., 1974.

This is about a little girl's feelings toward her best friend and some of the anxieties she feels when they have an argument. There are full page color photographs that accompany the text. Ages 2½ and up

Berger, Terry, A Friend can Help, (see Section on DIVORCE)

Berger, Terry, Being Alone, Being Together, Milwaukee, Advanced Learning Concepts, Inc., 1974.

Large color photographs go along with this simple text about a boy telling the positive aspects of being alone as well as those of being together with a friend. Ages 2½ and up

Fassler, Joan, The Boy With a Problem, New York, Behavioral Publications Inc., 1971.

A small boy named Johnny has a problem that causes stomache aches, to have trouble sleeping and a loss of appetite. He goes to his mother and teacher who tell him not to worry, the problem will disappear--but it doesn't. It's his friend Peter who helps Johnny by taking the time to listen and show he cares. Rather unusual drawings illustrate the text. Ages 3½ and up

Gold, Phyllis, Please Don't Say Hello, New York, Human Sciences Press, 1975.

This story is about Eddie, an autistic child. The text is long and deals with the nature of his experience, the school he attends, and other children's acceptance of him. Black and white photographs illustrate the text. Age 5 & up

Zolotow, Charlotte, My Friend John, New York, Harper & Row, 1968.

The value of friendship is explained very simply by a little boy telling about his best friend John. A very good book for teaching children the beauty of friendship. Sharing and a "give and take" type theme is emphasized as part of being a firend. Ages 2½ and up

TRANSITION INTO A NEW PROGRAM

Wolde, Gunilla, Betsy's First Day at Nursery School, Random House, New York, 1976

A lighthearted description of the nursery school experience. As a newcomer, Betsy explores the routines, equipment and most importantly, the friends at Nursery School. Might be useful for helping with the transition from home to school. Ages 2-5

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Valerie, a visually impaired child, describes some of the frustrations of visual impairment as well as some of the special adaptations which help her to maximize her mobility and participation. Valerie's a strong character who inspires self-respect. Ages 4-6

Yolan, Jane, The Seeing Stick, New York, Thomas Y. Crowell Co., 1977, $6.95.

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Resources have been organized under the following general headings:

Activities for Young Children
Assessment/Evaluation
Developmental Delay
Catalogs of Learning Materials
Early Childhood Education for the Handicapped
Early Childhood Education - General
Emotional Needs
For and About Parents
Learning Disabilities
Magazines
Mainstreaming
Physically and Otherwise Health Impaired
Reference Guides
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Staff Development
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Compiled by Helene Ginsberg and PATHWAYS Staff

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Easy to read -Designed to assist the teacher in helping the child to adjust emotionally to the setting and to his/her disabilities.

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An illustrated handbook of medical information concerning physically handicapped children. Fundamental medical facts are presented and accompanied by practical suggestions. Excellent!

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General introduction to the characteristics of exceptional children, and various educational approaches. Emphasis on classroom techniques and practices and the psychological, medical and sociological aspects of the different handicapping conditions.

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A simple presentation and explanation of normal language development and early signs which might indicate problems.

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Ideas for stimulating language development in hearing impaired children.

Gallaudet College Bookstore, A Guide to the Selection and Use of the Teaching Aids of the Signed English System,

Introduction and bibliography to books available from the Gallaudet College Bookstore. Many preschool, picture books available.

Hansen, Susan M.A., CCC-SP, Getting a Headstart on Speech and Language Problems: A Guide for Preschool Teachers, Early Childhood Technical Assistance - Resource Center - U. of Nebraska, 1974.

A guide to speech and language problems in the classroom. Guidelines of when to refer a child for speech and language services and how to conduct general language stimulation.

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Practical, imaginative and stimulating material for auditory training with children. Games with sounds, music, voice, distance and directions.

Northcott, Winifred H., Ph.D., Editor, Curriculum Guide: Hearing Impaired Children (0-3 years) and Their Parents, The Alexander Graham Bell Association for the Deaf, Inc., 1977.

An excellent curriculum guide for working with young hearing impaired children and their families. Discusses listening skills development, integration into regular nursery school and comprehensive services to the family.

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A collection of articles based on considerations and experiences in integrating hearing impaired children. Excellent sections on the preparation for integration and on the preschool years.

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Fry, Betty, and Carrie Hovell, Effective Approaches; a Manual for Teachers of Handicapped Preschoolers, East Central Kansas Head Start, Ottawa, Kansas, 1975.

A training manual for use in Head Start, nursery school programs. Has many good resources for developing expertise in teachers regarding special needs.

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A workbook for developing instructional materials for teacher training.

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Excellent longitudinal study of development of blind infants. New insights and applications.

International Institute for Visually Impaired, 0-7, Inc., 1975 Rutgers Circle, East Lansing, MI 48823 Phone: 676-3398, contact: Sherry Raynor, Donna Heiner, Carol Rottman.

Excellent resource for materials for working with the young visually impaired child and family.

Raynor, Sherry and Richard Drouillard, Get a Wiggle On, Ingham Intermediate School District, 1975.

Stimulation ideas for visually impaired infants. Expecially for parents.

FOR AND ABOUT PARENTS OF YOUNG HANDICAPPED CHILDREN IN THE MAINSTREAM

by Mary Wandschneider
and Helene Ginsberg

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FOR AND ABOUT PARENTS OF YOUNG HANDICAPPED CHILDREN IN THE MAINSTREAM

by Mary Wandschneider and Helene Ginsberg

The Effects on the Family of Having a Handicapped Child

Parental expectations and anxieties in regard to the anticipated birth of a child are normal. Will the child be a boy or girl? Will the child have the father's red hair and/or the mother's pug nose? Sometimes the child is not "just" what the parents may have (secretly) hoped for. (Another girl? Twins?) Often the experience of "parenting" itself was not expected (7 months and still doesn't sleep through the night?) Nevertheless, usually the parents adjust quickly to the ambivalence or possible disappointment; and the child, and all the characteristics of the child, are accepted by the family.

However, for the child who is considered "handicapped" following birth, there are usually significant differences in adjustment. The child, the parent(s) and the rest of the family and friends must adapt to, and ultimately understand, a potentially permanent difference. They may have to adapt to additional time demands with the special care and training needs of the child. They may have to adapt to additional cost demands with the special equipment and programs the child may need. They may have to adapt to "out of the norm" personality, appearance, or skills of their child. They may have to work with a variety of different professionals in the course of their child's growth and development. They may have to deal with emotional overloads; such as realizing that their child must work harder than the average person, but still may achieve less. They may have to comprehend and accept society's lack of understanding of their child. These are but a few of the countless concerns which families of handicapped children may have to face.

Necessary family adaptations have varied effects on the family of a handicapped child and much has been written describing these effects (see bibliography at the end of this section for references). However, two important cautions must be considered in viewing those findings: (1) not all families respond in the stereotypical ways, and (2) all families will be at different points in the adaptation to their special child - not necessarily linked to the child's age. Furthermore, while it may be useful to consider a few generalizations, it must be remembered that individual family reactions <u>are</u> highly unique - based on variables like personality, aspirations, social class, amount and quality of support, marital interactions, feelings about differences, etc.

Regardless of the individual pattern of adaptation, it is likely that having a handicapped child will, at times, be frustrating and stressful to the family. It is important to realize that there may be recurrent problems. A family may "accept" the fact that their child has a handicap, but not with calmness and ease. Coping with the problems surrounding a handicapped child in the family is not like a single crisis such as a death in the family - it's ongoing and unrelenting.

The literature abounds with generalizations about the reactions of and effects upon the family of having a handicapped child. Generalizations/concepts frequently cited are: grief/sorrow; denial/lack of acceptance; guilt/shame; anger; self-pity; loss of self-esteem; ambivalence; depressions; self-sacrifice and mutual dependence; and defensiveness/sensitivity to criticism of the child. Philip Roos (1975) discusses some additional philosophical conflicts that affect us all, but may become particularly salient to parents with the birth of their handicapped child. These include: disillusionment, aloneness, vulnerability, inequity, and insignificance. (See references at end of this section for further discussion.) But the families' reactions need not be all negative. It is important to note that better coping skills, increased strength, maturation, enhanced sensitivity, and other positive qualities may also be reactions of the family.

It is critical that teachers and others working with families who have handicapped children recognize that any of their parents may be responding in one or more of these different ways. Furthermore, the responses may vary in intensity and importance from individual to individual. They may appear and disappear with such

things as: milestones the child doesn't reach (walking, talking, etc.), achievement of goals by siblings, family crises, and life changes. For parents who have handicapped children, it is important to remember that these are normal reactions to the situation.

Parents of handicapped children may have different types of reactions when their child enters a "regular" classroom setting. It may be tremendously exciting to see one's own "special" child entering into a group of "normal" children. It may also prompt comparisons between one's own child and the non-handicapped children, perhaps restimulating feelings of loss or the symbolically felt "death" of the "ideal" child. Parents may also worry about how other children will aceept their child - "will she be teased? Am I doing the right thing?" On the other hand, many parents are delighted to be able to interact with parents of non-handicapped children discovering that their three-year-old's stubbornness has more to do with her being three, than with the fact that she has cerebral palsy. By being aware of the different issues that may be experienced by parents as they approach the mainstreamed setting, professionals can be more sensitive and supportive of parents.

Parents and Professionals Working Together

Professionals working with the child are important to the family. Often the supportive attitude of someone who is clearly positive and realistic, but enthusiastic, about the handicapped child is a tremendous boost to the parents' morale. A professional can accomplish a great deal just by teaching the parents what to expect and by showing that things can be and are being done.

Another useful resource for parents is other parents of handicapped children. The other parents' understanding and helpful ideas can be extremely beneficial. (See the Community Resources section of this packet for a listing of local groups for parents of handicapped children.) So one way in which center staff can help families who have handicapped children is to give them information about parent groups. Center staff may offer to host a meeting of the parent group or provide a ride or the name of a person to contact. The first step is an important one.

One of the most significant things individuals working with handicapped children and their families can do is to encourage staff and parents to work together. (See bibliography at the end of this section for references on parents and professionals working together.) But expect varied reactions to the idea of working together because of past experiences: some parents and/or staff members may enthusiastically embrace cooperation, while others may reject cooperation, at least initially.

As Kathryn A. Morton, Director, Montogomery County Association for Retarded Citizens, Michigan, has said so well:

> "In the course of raising a handicapped child most parents will encounter a large number and many kinds of professionals--physicians, psychologists, teachers, etc. Some will be helpful and others will not. Likewise, professionals whose trade is the handicapped child will encounter a large number and many kinds of parents. Some will be informed, cooperative and helpful; others will not. It seems safe to wager, however, that the quality and quantity of help and support the child receives will hinge on the ability of the parent and professional to deal effectively with each other. Parents are generally the people who know their child best and the professional should respect and utilize that knowledge. The professional is generally expert in his specialty. It should be part of his obligation to communicate his insights and information to the parent. And both should keep in mind that it is the parent who must shepherd his child through the array of services he will need in the process of growing up. The more information and understanding the parent gets from the professional the better the job he will do." (Montgomery County Association for Retarded Citizens, Information Sheet, "Parent and Professional Communication," 1975, p. 1)

The handicapped child, the professional and the parents all have much to gain by working together. The degree of a child's growth depends upon clear communication and cooperation between parents and professionals. That communication and cooperation depends on the following five areas: (1) mutual understanding of perspectives, (2) coordination of services, (3) direct communication, (4) information, and (5) encouragement.

In order for parents and professionals to effectively work together, it is critical that both understand each other's perspectives. Professionals may have particular strengths, weaknesses, concerns, priorities vis a vis the handicapped child. Parents need to know these. Similarly, if professionals don't understand parents' perspectives, cooperation is probably unattainable. Parents may have limitations on their time and/or commitment to one or more therapies or other critical tasks. Parents (or professionals) may have invested much previous energy in working with individuals, may have seen those people leave, and feel strongly that they have little energy left. Parents (or professionals) may have had negative previous experiences with individuals which may operate as strong impediments to cooperation. Or parents may have been a part of a successful team effort somewhere else, and may want to continue a particular program which is valued less in the new situation. If an attempt to understand these existing perspectives is not made, the potential for cooperative endeavors may be seriously limited. It is easy to begin a relationship with incorrect assumptions.

Another basic element of parents of handicapped children and professionals working together is coordination of services. Most handicapped children experience a variety of adults working with them, often simultaneously. The parent(s) are part of that "team." In order for the child to optimally develop, first there must actually be a "team," and that team must coordinate its efforts. Each member must communicate with other members, and together try to see the constellation and complexity of skills or needs of the child, rather than simply look at one narrow aspect. If coordination is not achieved, there may be: (1) problems in consistency of programs, or conflicting goals and objectives among the members of the team; (2) problems with overload of parental "duties" established/mandated by the team; (3) problem of coordinating timing and assuring that no significant areas are left out; (4) problems of "turfdom" among team members who may not understand what other professionals or paraprofessionals are doing; (5) problems of leaving parents out. It's not easy to bring team members representing diverse perspectives together, but that coordination and "teamwork" are essential to effective growth for the child.

Another significant area related to parents and professionals working together is communication. Any form of communication must be based on respect: that both groups can learn from each other, and that parents can understand. Communication takes time. Many professionals talk at parents, but understanding requires listening also. If every meeting has a professionally stacked agenda and is limited by another meeting scheduled immediately afterwards, communication will only be one-way - from the professional. Clearly that is not the form of communication we are seeking. Some important elements in communicating include:

For Professionals:

(1) Create opportunities for parents to talk.

(2) Use terminology of parents - if technical terms or professional jargon must be used, make sure parents understand the terms.

(3) Work with both parents whenever possible. If there is only one parent, try hard to understand the problems facing single parents.

(4) When introducing serious problems remember you may need to repeat the information in another setting at another time. If parents are thinking about the just mentioned problem, they may not hear what else you say, and they may not be able to quickly organize their own questions or thoughts.

(5) When reporting to parents:

- include discussion about the whole child (social/emotional development, as well as cognitive or motor development).
- include discussion of the positives as well as the negatives.
- suggest specific courses for action, plans to deal with problems.

For Parents:

(1) Recognize that you are a vital member of the team, and that your views are important - share them.

(2) Also recognize that many professionals working with your child may have had little experience working with parents, but you need their knowledge to help your child. Keep trying to build bridges, even though you may feel they're mostly coming from your side of the river.

(3) Whenever a professional uses technical terminology or jargon you don't know, make sure you ask for an explanation. The more you know and understand, the better you'll be able to communicate with professionals. Don't accept "It's too difficult to explain." If it is too difficult, the communication shouldn't have been started.

A fourth essential to parents and professionals effectively working flows out of communication; it is information. Parents may be asked to share or want to share information about their child. Professionals may also share information, and usually have a good start as most parents of handicapped children are typically anxious to receive information about their child. Nevertheless, professionals do not always provide parents with even basic information. Some parents may seem very well informed, but it may still be useful to summarize the following for them. Other parents may have received little information and details on the following may be of enormous use to them.

- Description of handicapping condition and etiology.
- Description of community services and programs such as school programs, therapies, recreation, parent groups, family counseling, respite care.
- Concrete description of treatment, management, day-to-day actions that may help the parents.
- Legal rights and laws.
- Copies of written reports in layman's terms.
- Discussion with parents about their role as advocates for their children.

A final area to keep both parents and professionals effectively working together is encouragement. At times either parents or professionals may become discouraged about the handicapped child's progress, or the enormity of the task of teaching that child. Progress can be slow. In order to keep trying, both the professionals and parents need encouragement from each other. They need to know that someone (who also knows the child) understands what they're trying to do, thinks they're doing a good job, and cares.

It is certainly not an easy task for professionals and parents of handicapped children to try to mutually understand each other's perspectives, to facilitate coordination of services for the child, to communicate with each other, provide information for each other, and give encouragement to each other. Yet both

parents and professionals need support and help in being as competent as possible in providing help to the child. The child's growth will be faster and better when parents and professionals learn how to effectively communicate and cooperate.

Starting Out: Helping Your Special Child's Transition into an Early Childhood Program

Your child will be attending a day care center or nursery school. Why not help him/her to adjust to the new teachers and adults, the new environment, and being away from you? Try to see nursery school or day care from your child's viewpoint - strange, exciting, stimulating, scary and NEW!!! As a parent, you are introducing your child to a priceless opportunity, the chance to learn and play with other young children in a setting designed especially for children: a setting where it's okay to touch, play, and experiment - with the guidance of caring and sensitive teachers. For your child, day care and nursery school will probably seem tempting and exciting. The whole experience will be new - having to wait for a turn, taking directions from adults who are not Mommy or Daddy, being one child among many. How different for the young child who has only experienced a very limited world! You can help the NEW become the FAMILIAR for your child. These are some strategies which have worked for other parents:

1. Decide for yourself that nursery school or day care will be a good experience for your child. Although you may have ambivalent feelings - can strangers care for my child? I don't want to leave my child - try not to share these feelings with your child. Talk about them with other adults. Often children can sense their parents' feelings and may manipulate the negative feelings to resist separation or change. Be positive and confident with your child when talking about and visiting the child care program. Your child will pick up your attitude!
2. Shortly before going to visit the center, talk with your child about going to a new school with other children.
3. Use the teacher's name: "We're going to visit Sally, she will be your teacher."
4. Invite your child's teacher to make a home visit so that your child can meet this new person in the comfort and security of your home.
5. If you have a chance, drive or walk by the child care center with your child a few times before she or he begins to attend. You don't have to make a big deal about it, just point it out.
6. Some parents like to visit the program alone before they bring their child. That gives them a chance to know what to expect, to anticipate what their child will be interested in.
7. Be relaxed on your first visit with your child. Have ample time on your first visit so that your child can explore comfortably. Let your child explore and participate at his/her own pace.
8. Talk to your child about the different activities, children and toys in the room. Invite him or her to play with you in different parts of the room, but don't push. And don't be surprised if your child is content to just watch!
9. Keep your visit short - leave before your child loses interest. It is better generally to leave before the child wants to go home, thereby increasing his interest and eagerness to return.

10. Once your child begins to attend day care or nursery school on his or her own, you will have to leave your child with the new teacher. This is often a difficult step. In most cases, instead of prolonging the "agony" of separation, it is helpful if you can drop off your child, stay a few moments, say, "Good-bye, I'll come back to get you later," and leave your child in the capable teacher's hands. This makes it clear to your child that it's time for you to go and him or her to stay. Soon he/she will learn that you <u>will</u> return, and will begin to look forward to nursery school or day care. Sometimes it helps to leave your child for only part of the session the first few days. This shortens the initial anxiety for you both.

11. Security is important to young children. Often a familiar toy, blanket, or other treasure from home allows him or her to bring part of the "known" into the "unknown."

12. Let your child know (through verbal praise, hugs, kisses, little rewards) how proud you are of his/her going to "school." Show your interest in what happens at school, what your child does. This will help him/her to feel like "school" is important and valuable.

The transition from home to school is an important one. It can be made easier by the supportive parent.

<u>How Parents can be Helpful to Teachers</u>

Parents are experts about their own children - in a very special way. You have known your child longest, have seen him or her grow and develop. You have seen your child in many different settings. You know your child's likes and dislikes, and have learned to understand unique signals. More than anyone else in the world, you care about your child - and that caring is the basis for your expert knowledge.

Your child is unique and has certain special needs, abilities and problems. As your child enters a nursery school or day care center, you will be sharing some of the responsibility of caring and teaching with your child's teacher. By working as a team with that teacher, you will be able to continue to positively influence your child's development. There are many ways in which you can help your child's teacher - by sharing your knowledge, experience and understanding of your child! Especially during the first weeks and months of your child's nursery school or day care experience, you can be helpful and supportive by helping the teacher get to know your child. Here are some ways in which you can be helpful:

1. <u>Share basic information</u> about your child's speical needs. If you can speak comfortably and openly about your child's needs and abilities, the teacher will be better able to help your child. Share <u>facts</u> of your child's disability - as you know them. You may want to discuss the <u>cause</u> of the disability (if it is known), the <u>severity</u> of the disability, and the <u>other professionals</u> and agencies involved with your child (speech therapist, occupational therapist, etc.). Remember - a nursery school or day care teacher may not have had experience with a child with special needs - you can help by being an "educator."

2. <u>Share information about what your child can do</u> - Talk about your child's strengths, abilities and skills. Your child may be very friendly and caring about other people or he may have great patience in putting together puzzles. By talking about these strengths, the teacher can, with your help, plan activities with which your child may be successful. By focusing on strengths, the teacher will be helped to promote your child's independence.

3. Point out your child's favorite activities - What games or toys does your child especially enjoy? In what songs or music does your child delight? Any favorite foods which could be served at snack time? This valuable information can greatly help the teacher to welcome your child into the classroom, and help him or her feel comfortable and appreciated.

4. Fully explain any special health needs, medication, limits on activity. Demonstrate the use of special equipment or devices. The teacher will feel much more comfortable if she knows how to put the hearing aid back in when it comes out, or if she really understands that there are no limits on your child's activities.

5. Share your goals for your child - What are the skills you are working on at home? Let the teacher know! What do you think your child needs help with learning? What is most important to you? You may be more concerned with your child learning to play with other children than with learning the alphabet. The teacher will want to know these goals. It is also helpful to share the goals that other professionals are working on with your child. For example, if the speech therapist is working on having your child use a louder voice, the nursery school or day care teacher can follow up with activities to practice this skill.

6. Communicate! Use notes, phone calls or chats. Let the teacher know about changes at home which may affect your child's behavior at school. Tell her about special events or experiences which can be talked about or expanded upon at school. Tell the teacher about new skills or about problems. By communicating, you can pool resources and work as a team.

7. Ask questions! Find out what your child is learning and doing. Does he enjoy himself? Is she learning to play in a group? Are the activities at the child's level? You must continue to monitor your child's program, so that together with the teacher, you can work towards your child's optimal development.

8. Show your appreciation. We all like praise. The nursery school or day care teacher has a difficult and challenging job, just as you do. Let her know what a good teacher she is. And watch her grow! And glow...

Effects Upon the Family of Having a Handicapped Child

and

Parents of Handicapped Children and Professionals Working Together

An Annotated Bibliography, 1979

Barsch, Ray H., The Parent of the Handicapped Child, Springfield, Illinois: Charles C. Thomas, Publisher, 1976.

A study of child-rearing practices on the manner in which a parent adapts to the role of rearing a handicapped child. Barsch uses research findings to outline well-defined information about the entire family structure in dynamic daily living experiences. For parents of handicapped children and for professionals who work with parents.

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Graham, Kathryn A., "A Lost Generation of Parents," Exceptional Children, May 1975, pp. 521-525.

Suggestions to parents and professionals for working together. Written by a parent.

Heisler, Verda, A Handicapped Child in the Family, New York, NY, Grune & Stratton, 1972.

A book for parents of children with any kind of physical or mental problem. The book uses sensitive accounts of parents' experiences and feelings to describe how parents respond to having a handicapped child. Dr. Heisler is handicapped as a result of severe physical impairments of childhood polio. She has practiced as a psychotherapist of families with handicapped children for years.

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Effects on the family of having a handicapped child. Written by psychologists who have worked with parents.

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Ideas for professionals to aid in communicating with parents (same ideas often useful to parents as well).

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A detailed framework for the planning, organizing, and supervision of parent-involvement activities in early childhood programs for the handicapped. It brings together suggestions of eighteen psychologists and educators experienced in working with parents and children. (Contributors are associated with the Handicapped Children's Early Education Program Network (HCEEP)).

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Schild, Sylvia, "The Family of the Retarded Child," in Koch, Richard and Dobson, James C., The Mentally Retarded Child and His Family, A Multidisciplinary Handbook, New York, NY, Brunner, Mazel Publishers, 1971.

Effects on the family of having a handicapped child. Written by a social worker.

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Effects on the family of having a handicapped child, and principles in family counseling. Written by a social worker. Other chapters in this book include numerous reactions of families to handicapped children.

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INDIVIDUAL DIFFERENCES: INDICATIONS AND DEFINITIONS OF SPECIAL NEEDS IN EARLY CHILDHOOD

by Helene Ginsberg,
Sally Atkins-Burnett,
and Carol Fredrickson

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Sally Atkins-Burnett,
and Carol Fredrickson

Not all children who may be handicapped come to the preschool setting identified as having handicaps. The following sections are included in this handbook in order to give some indicators of special needs. The sections are written for regular classroom preschool teachers. That they may also be read and understood by parents is assumed. First is a brief overview of "normal" child development. Next is a section of specific indicators of particular handicapping conditions. The final section includes definitions of handicapping conditions.

A Brief Overview of Normal Child Development

The following "Preschool Profile" provides a brief, and useful overview of representative skills that most children exhibit during the first six years of life. The "Profile" suggests the appropriate age ranges in which these skills typically occur.

As you become familiar with the behaviors that generally occur in normal child growth and development during this time, you will better learn what to expect from children at each level. With a realistic set of expectations, you will then be able to evaluate a particular child's developmental skills and plan activities to promote growth. These developmental guidelines may help you to identify children with developmental delays who may need further diagnostic evaluation and specialized help. Do keep in mind that children exhibit much variability in the ages at which they achieve developmental skills. This profile suggests age ranges rather than specific age levels for skill accomplishment and reflects the individual nature of each child's unique development.

The "Preschool Profile" includes the full age range from birth to age six. As such, it is very useful for children who may be at a different developmental level in one or more skill areas, as well as providing information regarding the sequence or order of skill development. Again, this generalized sequence can suggest the "next step" of development that you can plan for classroom or home use.

Preschool Profile*

	GROSS MOTOR SKILLS	FINE MOTOR SKILLS	PRE-ACADEMIC SKILLS	SELF-HELP SKILLS
0-12 months	SITS WITHOUT SUPPORT. CRAWLS. PULLS SELF TO STANDING AND STANDS UNAIDED. WALKS WITH AID ROLLS A BALL IN IMITATION OF ADULT	REACHES, GRASPS, PUTS OBJECT IN MOUTH. PICKS THINGS UP WITH THUMB AND ONE FINGER (PINCER GRASP) TRANSFERS OBJECT FROM ONE HAND TO OTHER HAND DROPS AND PICKS UP TOY.	LOOKS DIRECTLY AT ADULT'S FACE TRACKS OBJECTS (FOLLOWS THEM SMOOTHLY WITH EYES). IMITATES GESTURES E.G., PAT-A-CAKE, PEEK-A-BOO, BYE-BYE. PUTS BLOCK IN, TAKES BLOCK OUT OF CONTAINER. FINDS BLOCK UNDER OVER CUP.	FEEDS SELF CRACKER; MASHING, NOT SUCKING HOLDS CUP WITH TWO HANDS, DRINKS WITH ASSISTANCE. HOLDS OUT ARMS AND LEGS WHILE BEING DRESSED.
12-24 months	WALKS ALONE. WALKS BACKWARD PICKS UP OBJECT WITHOUT FALLING PULLS TOY. SEATS SELF IN CHILD'S CHAIR. WALKS UP AND DOWN STAIRS WITH AID	BUILDS TOWER OF 3 CUBES. PUTS 4 RINGS ON STICK. PLACES 5 PEGS IN PEGBOARD TURNS PAGES 2 OR 3 AT A TIME. SCRIBBLES.	FOLLOWS ONE DIRECTION INVOLVING FAMILIAR ACTIONS AND OBJECTS E.G. GIVE ME (TOY) SHOW ME (BODY PART) SET A (FAMILIAR OBJECT) COMPLETES 3 PIECE FORMBOARD MATCHES SIMILAR OBJECTS	USES SPOON, SPILLING LITTLE DRINKS FROM CUP, ONE HAND UNASSISTED. KNOWS FOOD REMOVES GARMENT ZIPS, UNZIPS LARGE ZIPPER INDICATES TOILET NEEDS
24-36 months	RUNS FORWARD WELL JUMPS IN PLACE, TWO FEET TOGETHER. STANDS ON ONE FOOT, WITH AID. WALKS ON TIPTOE KICKS BALL FORWARD THROWS BALL, WITHOUT DIRECTION	STRINGS 4 LARGE BEADS TURNS PAGES SINGLY SNIPS WITH SCISSORS HOLDS CRAYON WITH THUMB AND FINGERS, NOT FIST USES ONE HAND CONSISTENTLY IN MOST ACTIVITIES IMITATES CIRCULAR, VERTICAL, HORIZONTAL STROKES	MATCHES SHAPES STACKS 5 RINGS ON PEG IN ORDER DEMONSTRATES NUMBER CONCEPTS TO 2 (I.E. SELECTS SET OF 1 OR 2, CAN TELL HOW MANY, 1 OR 2).	USES SPOON WITH SPILLING. GETS DRINK UNASSISTED USES STRAW OPENS DOOR BY TURNING HANDLE. PUTS ON TAKES OFF COAT WASHES AND DRIES HANDS WITH ASSISTANCE.
36-48 months	RUNS AROUND OBSTACLES WALKS ON A LINE. BALANCES ON ONE FOOT 5 SECONDS HOPS ON ONE FOOT PUSHES, PULLS, STEERS WHEELED TOYS RIDES (I.E., STEERS AND PEDALS) TRIKE USES SLIDE WITHOUT ASSISTANCE JUMPS OVER 15cm (6") HIGH OBJECT LANDING ON BOTH FEET TOGETHER FOCUSES BALL WITH DIRECTION CATCHES BALL BOUNCED TO HIM	BUILDS TOWER OF 9 CUBES DRIVES NAILS AND PEGS COPIES CIRCLE IMITATES CROSS	MATCHES 6 COLORS MAKES TOWER OF 5 BLOCKS, GRADUATED IN SIZE DOES 7 PIECE PUZZLE COUNTS TO 5 IN IMITATION OF ADULTS DEMONSTRATES NUMBER CONCEPT TO 3	POURS WELL FROM PITCHER. SPREADS SUBSTANCES WITH KNIFE BUTTONS UNBUTTONS LARGE BUTTONS. WASHES HANDS UNASSISTED. CLEANS NOSE WHEN REMINDED USES TOILET INDEPENDENTLY FOLLOWS CLASSROOM ROUTINE WITH MINIMUM TEACHER ASSISTANCE. KNOWS OWN SEX KNOWS OWN AGE KNOWS OWN LAST NAME
48-60 months	WALKS BACKWARD HEEL-TOE HOPS FORWARD 10 TIMES, WITHOUT FALLING WALKS UP/DOWN STAIRS ALONE, ALTERNATING FEET THROWS OVERHAND	CUTS ON A LINE CONTINUOUSLY. COPIES CROSS COPIES SQUARE. PRINTS A FEW CAPITAL LETTERS	POINTS TO NAMES 6 BASIC COLORS POINTS TO NAMES 3 SHAPES MATCHES RELATED COMMON OBJECTS E.G. SHOE, SOCK FOOT APPLE, ORANGE, BANANA DEMONSTRATES NUMBER CONCEPT TO 4 OR 5.	CUTS FOOD WITH A KNIFE. E.G. SANDWICH CELERY LACES SHOES KNOWS OWN CITY, STREET FOLLOWS INSTRUCTIONS GIVEN TO GROUP
60-72 months	RUNS LIGHTLY ON TOES. WALKS A BALANCE BEAM. CAN COVER 2 METERS (6'6") HOPPING SKIPS JUMPS ROPE. SKATES.	CUTS OUT SIMPLE SHAPES COPIES TRIANGLE TRACES DIAMOND. COPIES FIRST NAME PRINTS NUMERALS 1-5 COLORS WITHIN LINES HAS ADULT GRASP OF PENCIL. HAS HANDEDNESS WELL ESTABLISHED. (R.F., LEFT OR RIGHT HANDED)	SORTS OBJECTS ON ONE DIMENSION (E.G., BY SIZE OR BY COLOR OR BY SHAPE) DOES 15 PIECE PUZZLE COPIES MORE DESIGN NAMES SOME LETTERS NAMES SOME NUMERALS NAMES PENNY, NICKEL, DIME, QUARTER COUNTS BY RATE TO 10 CAN TELL WHAT NUMBER COMES NEXT	DRESSES SELF COMPLETELY LEARNS TO DISTINGUISH LEFT FROM RIGHT TIES BOW BRUSHES TEETH UNASSISTED CROSSES STREET SAFELY RELATES CLOCK TIME TO DAILY SCHEDULE

*This profile is a working draft only and was prepared by the Communication Program staff: Communication Disorders Specialists Linda Lynch, Jane Reike, Sue Soltman, and Teachers Donna Hardman and Mary C'Connor.

MUSIC/ART/STORY SKILLS	SOCIAL SKILLS AND PLAY SKILLS	UNDERSTANDING LANGUAGE	ORAL LANGUAGE
PAYS GAZE ON PICTURES IN BOOK.	SMILES SPONTANEOUSLY RESPONDS DIFFERENTIALLY TO STRANGERS AND FAMILIAR PERSONS. PAYS ATTENTION TO OWN NAME. RESPONDS TO "NO." COPIES SIMPLE ACTIONS OF OTHERS	LOOKS AT PEOPLE WHO TALK TO HIM. RESPONDS DIFFERENTIALLY TO VARIETY OF SOUNDS: E.G., PHONE, VACUUM, CLOSING DOORS, ETC. RESPONDS TO SIMPLE DIRECTIONS ACCOMPANIED BY GESTURES: E.G., COME, GIVE, SIT.	MAKES DIFFERENT VOWEL SOUNDS. MAKES DIFFERENT CONSONANT-VOWEL COMBINATIONS. VOCALIZES TO THE PERSON WHO HAS TALKED TO HIM. USES INTONATION PATTERNS THAT SOUND LIKE PHRASES: E.G., INTONATIONS THAT SOUND LIKE QUESTIONS, ASKING, TELLING.
MOVES TO MUSIC LOOKS AT PICTURES IN BOOK, POINTING TO, OR NAMING OBJECTS OR PEOPLE PAINTS WITH WHOLE ARM MOVEMENT. SCRIBBLES, SCRUBS, MAKES STROKES	RECOGNIZES SELF IN MIRROR OR PICTURE. REFERS TO SELF BY NAME PLAYS BY SELF; INITIATES OWN PLAY ACTIVITIES. IMITATES ADULT BEHAVIORS IN PLAY PLAYS WITH WATER AND SAND LOADS, CARRIES, DUMPS. HELPS PUT THINGS AWAY	RESPONDS TO SPECIFIC WORDS BY SHOWING WHAT WAS NAMED: E.G., TOYS, FAMILY MEMBERS, CLOTHING, BODY PARTS. RESPONDS TO SIMPLE DIRECTIONS GIVEN WITHOUT GESTURES: E.G., GO, SIT, FIND, RUN, WALK	ASKS FOR ITEMS BY NAME. ANSWERS WHAT'S THAT? WITH NAME OF OBJECT. TELLS ABOUT OBJECTS OR EXPERIENCES WITH WORDS USED TOGETHER (2-3 WORDS): E.G., MORE JUICE.
PARTICIPATES IN SIMPLE GROUP ACTIVITY E.G., DRUMS, CLAPS, DANCES CHOOSES PICTURE BOOKS, POINTS TO FIND DETAIL, ENJOYS REPETITION PAINTS WITH SOME WHAT ACTION. MAKES DOTS, LINES, CIRCULAR STROKES. ROLLS, PRESSES, SQUEEZES, POKES CLAY MATERIAL	PLAYS NEAR OTHER CHILDREN. WATCHES OTHER CHILDREN, JOINS BRIEFLY IN PARTLY PLAY REFERS AND POSSESSIONS ENGAGES IN DOMESTIC PLAY SYMBOLICALLY USES OBJECTS, SELF IN PLAY BUILDS WITH BLOCKS IN SIMPLE LINES	RESPONDS TO PUT IT IN AND PUT IT ON. RESPONDS BY SELECTING CORRECT ITEM BIG VS. LITTLE OBJECTS. ONE VS. ONE MORE OBJECT IDENTIFIES OBJECTS BY THEIR USE E.G., SHOW ME WHAT MOTHER COOKS ON BY SHOWING STOVE. OR SHOW ME WHAT YOU WEAR ON YOUR FEET. BY SHOWING SHOE	ASKS QUESTIONS. ANSWERS WHERE IS IT? WITH PREPOSITIONAL PHRASES: E.G., IN THE BOX, ON THE TABLE. ANSWERS WHAT DO YOU DO WITH A BALL? E.G., THROW, CATCH. TELLS ABOUT SOMETHING WITH FUNCTIONAL SENTENCES WHICH CARRY MEANING: E.G., WE GO STORE OR MY DOGGY RUN.
KNOWS PHRASES OF SONGS. LISTENS TO SHORT SIMPLE STORIES (5 MINUTES) PAINTING NAMES OWN PICTURE, NOT ALWAYS RECOGNIZABLE. DEMANDS VARIETY OF COLOR DRAWS HEAD OF PERSON AND ONE OTHER PART MANIPULATES CLAY MATERIALS E.G., ROLLS BALLS, SNAKES COOKIES ETC.	JOINS IN PLAY WITH OTHER CHILDREN. BEGINS TO INTERACT SHARES TOYS, TAKES TURNS WITH ASSISTANCE BEGINS DRAMATIC PLAY ACTING OUT WHOLE SCENES E.G. TRAVELING PLAYING HOUSE. PRETENDING TO BE ANIMALS	RESPONDS TO PUT IT ONTO AND PUT IT UNDER RESPONDS TO COMMANDS INVOLVING 2 OBJECTS E.G., GIVE ME THE BALL AND THE SHOE. RESPONDS TO COMMANDS INVOLVING 2 ACTIONS: E.G., GIVE ME THE CUP AND PUT THE SHOE ON THE FLOOR. RESPONDS BY SELECTING CORRECT ITEM E.G., HARD VS. SOFT OBJECTS RESPONDS TO WALK FAST BY INCREASED PACE, AND TO WALK SLOWLY BY DECREASED PACE.	ANSWERS WHICH ONE DO YOU WANT? BY NAMING IT. ANSWERS IF...WHAT & WHAT...WHEN QUESTIONS: E.G., IF YOU HAD A PENNY, WHAT WOULD YOU DO? WHAT DO YOU DO WHEN YOU'RE HUNGRY? ANSWERS QUESTIONS ABOUT FUNCTION: E.G., WHAT ARE BOOKS FOR? ASKS FOR OR TELLS ABOUT WITH GRAMMATICALLY CORRECT SENTENCES E.G., CAN I GO TO THE STORE? I WANT A BIG COOKIE
SINGS ENTIRE SONGS RECITES NURSERY RHYME "READS" FROM PICTURES (I.E., TELLS STORY) RECOGNIZES STORY AND REPEATS SIMPLE FACTS PAINTING MAKES AND NAMES RECOGNIZABLE PICTURES DRAWS A PERSON WITH 2-6 PARTS	PLAYS AND INTERACTS WITH OTHER CHILDREN DRAMATIC PLAY CLOSER TO REALITY ATTENTION TO DETAIL, TIME AND SPACE PLAYS DRESS-UP BUILDS COMPLEX STRUCTURES WITH BLOCKS	RESPONDS BY SHOWING PENNY-NICKEL-DIME. RESPONDS TO COMMAND INVOLVING 3 ACTIONS. E.G., GIVE ME THE CUP. PUT THE SHOE ON THE FLOOR. AND HOLD THE PENCIL IN YOUR HAND. ABOVE ITEMS ARE SELECTED FROM THE SCORED INVENTORY OF COMMUNICATION DEVELOPMENT, UNIVERSITY PRESS, UNIVERSITY OF WASHINGTON, 1975	ASKS HOW QUESTIONS. ANSWERS VERBALLY TO HI AND HOW ARE YOU? TELLS ABOUT SOMETHING USING PAST TENSE AND FUTURE TENSE TELLS ABOUT SOMETHING USING CONJUNCTIONS TO STRING WORDS AND PHRASES TOGETHER E.G., I HAVE A CAT AND A DOG AND A FISH.
RECOGNIZES RHYME ACTS OUT STORIES DRAWS A PERSON WITH HEAD, TRUNK, LEGS, ARMS, AND FEATURES PASTES AND GLUES APPROPRIATELY. MODELS OBJECTS WITH CLAY	CHOOSES OWN FRIEND(S) PLAYS SIMPLE EARLY GAMES PLAYS COMPETITIVE GAMES ENGAGES IN COOPERATIVE PLAY WITH OTHER CHILDREN INVOLVING GROUP DECISIONS, ROLE ASSIGNMENTS, FAIR PLAY USES CONSTRUCTION TOYS TO MAKE THINGS: E.G., HOUSE OF LEGOS, CAR OF BIG A-MA-JIG	SEE PRE-ACADEMIC SKILLS	CHILD WILL HAVE ACQUIRED BASIC GRAMMATICAL STRUCTURES (INCLUDING PLURALS, VERB TENSES, AND CONJUNCTIONS. FOLLOWING THIS DEVELOPMENTAL ADVENT, THE CHILD PRACTICES WITH INCREASINGLY COMPLEX DESCRIPTIONS AND CONVERSATIONS.

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Help! Am I Imagining It - Or Does This Child Have A Problem?: A Guide To Early Warning Signals of Special Problems In Early Childhood

Teachers and parents of young children are often the first to suspect that a child has a developmental problem or handicapping condition. The early identification and treatment of special problems can: help prevent more serious handicaps, help prevent a child's repeated failure and frustration, and promote the best adaptation of home and school to the child's needs.

Catching early signs of special problems is troublesome, especially since some "problems" have a tendency to disappear. Often more than one problem will be present, making it difficult to figure out what is the central or primary problem. For example - is a child delayed in his/her motor development because of poor self esteem or vice versa. Teachers often (and sometimes correctly) hesitate to discuss symptoms with parents - fearing to alarm the parents, or mistrusting their own knowledge. This brief guide provides basic information about what might be "problems" in the areas of vision, hearing, speech, language, physical health, mental health, learning abilities and intellectual development.

Uncovering special problems is similar to a detective's work. Regardless of the nature of the symptoms, you can follow the same simple process of: collecting information, working together with parents, referring to an appropriate medical/therapeutic resource and following up. Taking the following simple steps can help assure that the child's needs remain central to the process:

1. Collecting information. If you suspect a child of having a special problem, write down your observations. Record when the problem occurs, how often, what conditions seem to alleviate or aggravate. Keep track of the incidence, rate, frequency and characteristics of the child's difficulties. This information will help you to talk with parents and will help diagnostic personnel as well. If you are unsure of your own objectivity, ask another teacher or director to observe.

2. Include parents. Don't hesitate - share your concerns with the child's parents. You may find that the parents: have a simple explanation, have already sought help for the problem, or are worried about their child but don't know what to do. You may also find that parents: have not observed the problem at home, are unwilling to acknowledge the existence of the problem, or are not ready to accept suggestions. Most parents do want the best for their child and will welcome your interest and concern as long as you are positive, non-judgmental, objective and honest. Be specific, share your data, invite parents to observe, continue to collect data and persist until parents are ready to hear you. You can tactfully suggest: "I'd like to know more so that I can help Susie learn better," or "Maybe we should check this out to be sure there is no problem." Do not imply or suggest that you want the child out of your classroom, unless, of course, that is the case.

3. Refer to Medical/Therapeutic/Diagnostic Resources. Try to have a few referral options to suggest to parents and check to see if there is a cost involved. School districts are required to provide free diagnostic evaluations to any child suspected of having a handicapping condition. Offer to share your observations in writing with the doctor/clinic/psychologist, etc., with parents' permission. Help parents to make a checklist of questions that they want answered. Offer to go with parents for the evaluation. This last offer may prove to be a very significant step in establishing an ongoing relationship with the parents.

4. Follow-up. Stay in touch with parents! There may be a big delay between referral, evaluation and action. Support parents during this time by sharing the child's successful experiences. After an evaluation is made, obtain written parental permission to inquire about possible educational implications or adaptations for you in your classroom and for them at home.

The following is intended to help focus your observations and weigh different symptoms. When in doubt, REFER! It's better to find out there is no problem than to wait too long and later realize how much anguish could have been prevented.

Vision Problems

1. Physical symptoms that can be observed: (may be signs of allergy, infection, or difficulty seeing)

   - red rimmed, bloodshot, watery eyes
   - encrusted swollen eyelids
   - rubbing or rolling of eyes
   - excessive blinking
   - blocked tearducts
   - frequent sties

2. Child complains of:

   - dizziness, blurring, double vision
   - headaches, pains in the eyes, nausea

   These above symptoms could be due to middle ear infections, allergies, central nervous system dysfunction or poor vision.

3. Strabismus (crossed eyes): infants and very young children have faces so small that occasionally when they are looking at something closely, they appear cross-eyed. Occasional crossing of the eyes may be a problem of maturation of the nervous system and its control of eye muscles. In this case the problem will fade as child gets older. If only one eye crosses, the child's eyes should be checked to assure that (s)he is using both of them correctly.

4. Misalignment of eyes or wandering eye: if one eye "wanders" in a different direction, or is not moving with the other eye, the child's vision should be checked. This will assure that one eye is not doing the work of two. The non-functioning eye is sometimes called a "lazy" eye.

5. Nystagmus (rapid, rhythmic, side-to-side movement of the eyes): this may be caused by: poor vision, middle ear infection, or a balance problem.

6. Peripheral difficulty - trouble seeing things that are off to side: the child may be bumping into other moving children because (s)he does not see them out of the corner of his/her eye. You can tell whether the child is using peripheral vision by telling him/her to look directly at your face; then quickly move or wiggle your hand out to the side. The child's eyes should be drawn toward the moving stimulus (your hand) if (s)he is able to use peripheral vision.

7. Lacks "normal" curiosity regarding objects visually presented: may be a problem with visual acuity or may be color blindness.

8. Cannot match or name colors: (for a child over three) first make sure that the child understands the task. Have him/her match common objects, shapes, etc., then have him try to match colors where color is the only difference (i.e. shapes and objects constant). If there is still a problem with some basic colors, (i.e., blue, yellow, red, green), you may want to suggest testing for color blindness. Color blindness usually occurs only in males and is a sex-linked gene. It is more common than previously thought.

9. Lack of response to facial expression of others: may be caused by a lack of social understanding or poor visual acuity (nearsightedness). If this occurs consistently, and/or along with other signs of visual problems, you may want to have vision checked.

10. Awkwardness with eye-hand coordination activities: be sure that the child is being asked to perform activities that should be easy for his/her developmental level of functioning. Check how well the child does with visual tasks if you are manipulating the objects (child is telling if something is same/different, etc.). Poor eye-hand coordination can be problem of motor control; it can also be a problem of poor body awareness, or poor vision.

11. Tilting head to one side: sometimes with an imbalance in muscle tone, tilting the head will help to keep the two eyes working together. (Children with cerebral palsy sometimes do this.) If this is the only way the child appears to see clearly, refer to an opthalmologist to see if glasses or exercises might help.

12. Distortion of face when using eyes: (frowning, squinting, closing one eye) usually indicates poor vision - refer for vision screening or to an opthalmologist.

13. Fails to see or runs into objects not in his direct line of vision: can be due to poor peripheral vision, farsightedness or poor body control. The child may walk in an over-cautious manner, stumble, hesitate or falter, due to a visual problem.

14. Holds visual work at abnormal distance (i.e. very close or very far away): if the child cannot otherwise see to finish work, vision should be screened.

15. Unduly sensitive to variations in light levels: may be a problem of nervous system maturation; if periodic, may be an allergy problem (especially if skin coloration is very fair). Refer to a doctor to check eye reaction to light.

16. Overly dependent on other senses: e.g., feels for the cup and rests the spout of the pitcher on it to pour; feels for things, etc. Have vision screened. If you need to refer to other than child's pediatrician, Department of Public Health offers free vision screening.

Hearing Problems

Children with colds will frequently have temporary hearing loss. If the problem is persistent (i.e. frequent colds or hearing loss seems to persist beyond cold), child should be referred to ear specialist and/or audiologist. Symptoms to be alert for are:

1. Failure to respond when called on in group: may be a problem with auditory attention, particularly if room is noisy. Inattention is almost always a learned behavior. Look for other signs of hearing problems.

2. Frequent need to repeat: especially comments and directions by an adult. Make sure you have the child's attention before giving any direction. Even if child typically says, "Huh?," do not repeat, just wait to see if child can respond. Often "huh?" is a delaying tactic, while (s)he processes what was heard. The tactic is employed by older children and adults as well. If the "huh" syndrome is due to a hearing impairment you would probably need to repeat directions louder, with gestures, or with rephrasing in order for child to understand.

3. Tendency to watch a speaker: if the child watches with unusual intensity, has less apparent difficulty when facing the speaker, or if a child cannot hear when people are not in his line of vision, have hearing checked.

4. Frequently watches others before beginning a task: may indicate inability to hear instructions, inability to understand instructions, or insecurity in beginning something new or difficult.

5. Difficulty in locating the direction from which another is speaking: can indicate poor hearing in one or both ears.

6. Habitual turning, 'cocking" or "cupping" an ear toward the speaker: can indicate the child hears better in one ear.

7. Frequently interrupting others: often without realizing he is doing so.

8. Strained or bewildered expression on the face for no apparent reason.

9. Appearance of being under constant tension and seeming to tire easily: the tension of straining to hear can be very tiring.

10. Hypersensitive to sound: may be very active, distractible or irritable when sound levels in the room are not constant.

11. Poor balance (equilibrium): especially if eyes are closed or blindfolded. This may indicate problems with the inner ear(s).

12. Speech problems: as a result of hearing problem, especially with high frequency (pitch) sounds such as "h". Sh, ch, z, s are also high frequency sounds, but children often do not learn how to produce them until 6 or 7 years of age.

13. Habitually speaking too loudly or too softly: can sometimes signify a hearing problem.

Speech Problems

Variations in speech patterns are common among young children, Nevertheless, some patterns/problems can be helped by early identification.

1. Cannot be understood by others, especially by other children: if the child is three years or older, this may be a problem.

2. Not yet speaking in sentences: particularly if the child is over four.

3. Omitting or substituting sounds: (s)he should be able to produce certain sounds at particular ages.

4. Lacks sufficient volume to be heard: may be a problem of breathing/speech coordination, insecurity about speech, about him/herself, or a family tendency. Check the child's volume on the playground or in an outside activity; it may be adequate outside.

5. Stuttering: common among 3½ - 5 year olds. If it persists much beyond five, it may be a cause for concern. Young children's motor coordination of the speech mechanism is not mature enough for them to be able to speak as quickly as they are thinking. Do not draw attention to problems with words or phrases, as you may frustrate a child more. Be patient and you speak more slowly to them: don't tell them to speak slower--just model speaking slowly and their speech will slow down also.

6. Lisp: again this may be common in young children, especially if they are missing some teeth. If it is causing embarrassment for the child, refer to a speech therapist right away.

7. Does not inflect voice appropriately: check for hearing problems. Lack of inflection may also indicate emotional problems if there is no affect (smile, frown, etc.) in face either. It may also be a problem indicating incoordination of breathing/speech mechanisms.

8. Voice range: if volume is regularly exceptionally loud or soft, this may indicate a problem.

9. Harsh, hoarse, or unpleasant sounding speech: may indicate problems with the vocal chords.

10. Draws adverse attention to self because of speech: refer to speech therapist whether you can define the problem or not.

You may refer speech problems to the school district, or to a speech and audiology clinic for further evaluation.

Language Problems

There are also variations in language development among children. Signs that might be appropriate to watch for are:

1. 2 years old and not combining 2-3 words: or if he/she is unable to choose an object name from among familiar objects.

2. Unable to follow 2 part commands.

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3. 2 years old or older and cannot point to at least some major body parts.

4. Cannot relate an experience (truth or imaginary): at 3, a short one, (reading pictures, etc.), at 4, a longer story, using some sentences.

5. Cannot answer question(s): e.g. "Who are you?" "What is your name?"

6. Does not use a variety of tenses: a four year old should do so and should also be able to form a question. Begin concerted effort to improve language skills if problem is detected. Referral to schools for additional assistance is appropriate.

Special Health Problems

Although there is also variation in physical development, a problem such as those described below should be discussed with parent(s) for referral to a physician.

1. Easily fatigued: can be indicative of a variety of problems. These include, but not limited to: allergies, metabolic problems, tactile defensiveness, poor breathing pattern, malnutrition, unusual family patterns of sleep, etc.

2. Grossly abnormal in size: medical problems should be considered.

3. Excessively restless or overactive: check to see if this occurs only in certain environments, as this may be more a function of the environment than the child. But it may also be due to: distractibility, overstimulation, immature motor development, allergies, abnormal nervous system development, problems with metabolism, hunger, hypersensitivity to touch or sound, etc.

4. Extremely slow or inactive: may be caused by poor circulation, metabolic problems, allergies, low muscle tone, etc. Check family patterns of behavior also.

5. Usually breathless after exercise: may mean allergies (asthma), poor circulation, poor breathing pattern, infection or inflammation of lower respiratory tract, lack of experience with exercise, etc.

6. Subject to frequent dry coughs, complains of chest pains: similar to above problems. This should be referred to a physician as soon as possible.

7. Flushes easily: has a slight blush color to cheeks, lips and/or fingertips. May indicate poor circulation.

8. Subject to low grade fevers, frequent colds: often this is caused by allergies. It may also be indicative of poor resistance to disease, poor nutrition, lack of adequate rest, etc.

9. Experiences seizures: move objects on which child could hurt him/herself. Observe and record for family and doctor: time, duration, description of seizure and events surrounding.

10. Faints easily: can be poor respiration, circulation, and/or poor nutrition. Refer to physician immediately.

11. Complains of pains in arms, legs and/or joints: can be lack of calcium (especially if legs are bowing); check fingernails for white spots. Complaints may also be due to: arthritis, allergic reaction, poor circulation, bruised strained bones or muscles. If legs begin collapsing involuntarily, see a physician as soon as possible.

12. Excessively hungry and/or thirsty: can be thyroid problem, diabetes, other metabolic problems, emotional insecurity, poor nutrition, neurological problem, etc.

13. Walks with unusual gait: i.e. walking pattern very dissimilar to others of same age. May be cerebral palsy, poor balance, immature development, low muscle tone or familial pattern. (Can refer to school district or Sparrow Hospital Developmental Assessment Clinic in Lansing, Michigan. Further precise evaluation may be performed by a physical therapist under a physician's direction/referral.)

14. Stands or sits with unusual posture: may cause bone and/or joint deformities; should be checked and corrected to prevent future problems.

15. Appears to be daydreaming: young children often "daydream" and this is usually nothing to be concerned about - it's their way of taking time out. Often during this time they process what they are learning. Persistent daydreaming which interferes with learning may be a concern; the environment may be too stimulating, a child may need to rest his eyes after having strained to see. It may also be a problem of depressed nervous system or (petit mal) seizure activity. Refer to a pediatrician for further investigation.

Behavior Problems

When you suspect difficulties in this area of development, take care to view the child objectively and to consider carefully the effect your classroom has on the child's behavior. The following characteristics are mentioned as being indications of impairment when they are *persistent over a long period of time, despite adaptations in the environment*. All children engage in some of these behaviors occasionally, especially when under stress.

1. Extremely disrupted by change in routine: common when there have been big changes at home, lack of routine at home, or changes of routine or personnel in classroom. When extreme reaction persists beyond an initial adjustment or readjustment period, discuss with the family.

2. Tantrums or reactions of explosive anger: persisting even when corrected, redirected or disciplined. This type of behavior is fairly common with two-year-olds, but may indicate a major problem if this type of behavior persists as child grows older.

3. Phobic-like responses: unusually frightened by particular events, people or things.

4. Ritualistic behavior patterns: insists on same order of events, objects - a rigid adherence to "sameness."

5. Enuresis (urinating) in inappropriate places: may be caused by anxiety or by illness (i.e., diabetes). Do not assume that it is caused by anxiety unless you have explored the other possibilities with parents and physicians.

6. Withdrawn, overly inhibited, or non-participating: especially after a reasonable time of getting used to classroom. If severly withdrawn, parents may wish to consult appropriate professionals in regard to a play therapist or special class placement.

7. Irresponsible, defensive, or blaming others: when behavior is chronic, the child may need professional attention.

8. Problems in paying attention: can be due to a variety of reasons. See section on learning problems.

9. Seeks excessive attention from adults: seems unable to make own choices, or to initiate interactions with people or materials. If this becomes established as a pattern, the child may have great difficulty in attempting to learn new skills and may resort to seeking attention through inappropriate or negative behaviors.

10. Bizarre or eccentric behavior: behavior which is completely out of character for children, usually self-destructive. If behavior seems repetitive and automatic, try to rule out seizure activity first. Whenever possible, with eccentric behaviors, ignore the behavior itself and ask the child to do something constructive which is closely related to what the child is doing (e.g., if biting hands, ask him/her to do a project which involves using both hands.)

11. Difficulty in building and/or maintaining interpersonal relationships: may indicate that the child lacks a (relatively) secure sense of self. The child may also lack models for how to interact with other children and how to initiate play. Sometimes children with this difficulty have a poor sense of social cues - they cannot interpret facial, verbal or body expressions well and are not able to interpret the causes and effects of social behavior.

12. Mood swings: may be unhappy, depressed, or very silly without reason. This type of emotional lability is sometimes seen in children who have allergies or who are tactile defensive (cannot tolerate touch well). Giving lots of firm (not soft) touch, helping child to calm him/herself when necessary by rocking, and offering emotional support is recommended.

Learning Problems

Listed are only a few of the symptoms that may be indicative of moderate to severe learning problems. School districts have procedures for screening.

1. Hyperactivity: a condition of very excessive activity level. There is a range of activity levels in all children and some very "busy" children may be seen by very calm adults as "hyperactive." Other children are truly overly energetic and keep active parents and teachers running in circles. Hyperactivity in young children is a symptom that can be due to many causes: allergies, hunger, pre-clinical diabetes, nervous system dysfunction, an overstimulating environment, etc. Observe whether this behavior occurs all of the time, or only some of the time - it may be a function of the environment. Helping the child to cope with gradually increasing levels of stimulation is appropriate, as well as investigating other (medical) solutions when recommended.

2. Perseveration: continuation of a behavior when it is no longer appropriate. The child may have difficulty shifting from one task to another, may repeat the same words or phrases over and over. This may be an attempt to achieve perfection at a task, or it may be the result of a poorly functioning nervous system. Perseveration can be likened to a needle stuck on a record, replaying the same sounds over and over. You can often help the child to break the perseveration pattern by using another sense modality.

3. Poor coordination: the child appears awkward or clumsy in both fine motor and gross motor performance. This often seems to be caused by poor feedback to the child's brain about his/her body. It can be an indication of problems in: body awareness, equilibrium (balance), body control and/or motor planning.

4. Mobility (Walking): the child might drag his feet or exhibit homolateral walking pattern (one sided walking - relying on one side to balance and one side to push off). Mobility problems are usually due to poor balance reactions and, if so, child needs increased practice balancing in sitting, crawling, kneeling and standing positions. May also indicate lack of ability to integrate information from both sides of body. Check to see if (s)he can reach across the middle of the body easily and whether child can visually track an object using both eyes together.

Mental Retardation

1. Overall slowness in development: characterizes and describes mental retardation. In young children, this slowness causes children to fall consistently behind other children in their ability: to learn, to retain what they have learned, to solve problems, to use language, and to play with others.

2. Rate of learning: perhaps the single most important concept in diagnosing mental retardation. Children with mental retardation have a slower overall rate of learning and development than other children their age.

3. Mental Retardation presents diagnostic problems. If you suspect a child of learning more slowly than others, first consider the following possibilities:

   a.) Mistaking one handicap for another: a child may not be responding, learning, or processing information because of a hearing loss, frequent seizures, etc.

   b.) Cultural differences: children from different cultural and ethnic backgrounds have begun with different languages, experiences and behavioral expectations. But these different backgrounds may make a child appear, in an Anglo society, as if he/she were retarded. Thus, all children must be observed performing within their own cultural milieu and speaking in their own language in order to get a true picture of their development. Any testing done must be *free of cultural bias.*

   c.) Maturational factors: children develop at different rates; some children may be mentally, behaviorally or physically immature, but not retarded. Through adolescence, boys appear to develop at a slower rate than girls.

4. Possible warning signs: be alert to the following symptoms -

   a.) Child appears to have difficulty receiving information coming from the environment - has difficulty understanding directions, seems confused about what is going on in classroom, has difficulty choosing, can't concentrate, seems less aware of surroundings.

   b.) Child appears to have difficulty processing information - difficulty remembering what he or she has seen or heard, what has happened. Child can't predict dangerous consequences, has difficulty following directions, doesn't interpret common environmental sounds, has difficulty with basic concepts.

   c.) Child appears to have difficulty using information. Verbal responses are limited; child doesn't communicate using words and/or gestures, child can't describe familiar objects. Motor responses are awkward, uncoordinated; there is poor eye-hand coordination: dressing, prewriting skills are limited.

   d.) Behavioral indicators: child resists change, seems confused, unable to make choices, does not play imaginatively or inventively, is hesitant to try new activities.

5. Diagnosis of mental retardation is most commonly made by a school psychologist using at least two standardized intelligence and adaptive behavior tests after other possible developmental problems have been ruled out.

Educational Definitions of Handicapping Conditions

The General School Laws of the State of Michigan define handicapping conditions in terms of the educational impact of the condition. In order to qualify for special education services, a child must experience characteristics which interfere with the child's ability to learn. Not all "handicapping" conditions directly interfere with a child's learning ability. In those cases, special services can be sought from other agencies. The laws defining eligibility for special education services are designed to insure that children who require such services do receive them; and to prevent the inappropriate or discriminatory labeling of children who do not require special education.

In Michigan, these legal definitions pertain to individuals aged 0-25, although they were originally designed for the school aged population - aged 5-18. The Special Education Code is currently undergoing revision and it is hoped that the revisions will result in a clarification of the special education definitions of preschool aged children.

The definitions offered on the following pages are interpretations of the legal/educational definitions of handicapping conditions as contained in the Michigan General School Laws of 1973. The terminology used is specific to Michigan; different terms may be used in other states.

Severely Mentally Impaired (SMI)

Defined as a lack of development in the cognitive domain (for a preschool child, the delay is usually seen in all areas). When evaluated by a psychologist, the child would appear to achieve less than 30% of what most children of his/her age achieve. It is usually predicted that persons will have great difficulty achieving, even achieving some of the self-help and vocational skills.

Trainable Mentally Impaired (TMI)

Defined by a 50% or below score on a comprehensive evaluation by a psychologist. The developmental delay will be primarily in the cognitive domain. Social, economic, or cultural factors must be ruled out. It is predicted that this individual will achieve self-help and limited vocational skills, but will have difficulty attaining academic skills.

Educable Mentally Impaired (EMI)

Defined by a score of 50-70% of what most children his/her age achieve. Social, economic or cultural factors must be ruled out. If school age, this child would be apt to score below 60% in reading and arithmetic.

Emotionally Impaired (EI)

Certification as emotionally impaired requires an evaluation by a psychologist psychiatrist or social worker. One or more of the following characteristics must be present:

1. Disrupts learning process of other students or himself over an extended period of time.

2. Extreme withdrawal from social interaction in the school environment over an extended period of time.

3. Manifestation of symptoms characterized by diagnostic labels such as psychosis, schizophrenia and autism.

4. Disruptive behavior which has resulted in placement in a juvenile detention facility.

Hearing Impaired (HI)

Certification of hearing impairment requires an evaluation by an audiologist (a person trained to test hearing) and an otolaryngologist (an ear, nose and throat doctor) to diagnose the hearing impairment as interfering with a child's learning.

Hearing impairments are described according to the extent of the loss (defined in terms of the number of decibels) or the amount of amplification required for the child to hear, as follows:

- No significant hearing impairment: not more than 25 decibel (db) loss; no significant difficulty hearing faint speech.

- Slight impairment: 25-40 decibel (db) loss; difficulty only in hearing faint speech.

- Mild impairment: 40-55 db loss; frequent difficulty hearing normal speech.

- Marked impairment: 55-70 db loss; frequent difficulty hearing loud speech.

- Severe impairment: 70-90 db loss; can understand only amplified speech.

- Profound impairment: 90 db loss; usually cannot understand even amplified speech.

Visually Impaired (VI)

Evaluation by an opthamologist (eye doctor) is required. Presence of one of the following characteristics indicates a visual impairment of educational significance:

a) Legal blindness refers to an individual with central visual acuity of 20/200 or less in the better eye with correction (e.g., what a normally-sighted person sees at 200 feet, this person with lenses would need to be no more than 20 feet away to see).

b) Central vision acuity of 20/70 or less in the better eye after correction. This means that to see what a person with normal vision sees at 70 feet, the visually impaired person with lenses would need to be no more than 20 feet away to see.

c) Peripheral field of vision restricted to no more than 20 degrees. This means (s)he can only see straight ahead.

Physically and Otherwise Health Impaired (POHI)

Evaluation by an orthopedic surgeon (bone doctor), neurologist (brain and nervous system doctor), pediatrician or other doctor is required to diagnose a physical or health impairment that interferes with learning or requires physical adaptation in the school environment.

Some of the problems that can interfere with learning are: seizure disorders; bone and joint disorders; congenital or surgical amputation (lacking a limb - an arm or leg); phocobelia (born with an arm or leg which is very small and thus near to the trunk of body); Myelodysplasia (spina bifida, myelomeningocele), an abnormality of the spinal cord and vertebrae; hydocephalus (sometimes called "water on the brain" - the fluid in the brain is not draining properly. This is now treated by inserting a shunt - a plastic tube to drain the fluid); cerebral palsy (damage to the parts of the brain that control movement and the control of the muscles). Other health impairments may include: muscular dystrophy, cystic fibrosis, Tay-Sachs disease, sickle cell anemia, severe diabetes, and congenital heart conditions.

Speech and Language Impaired (S/L)

Evaluation by a certified teacher of speech and language, a speech and language therapist or speech pathologist is required. One or more of the following verbal communication impairments must be present:

a) articulation errors, including omissions, substitutions or distortions of sound

b) inappropriate voice pitch, rate of speaking, loudness or quality of speech

c) fluency of speech distinguished by speech interruptions (blocks), repitition of sounds, words, phrases or sentences which interfere with effective communication

d) inability to understand, formulate and use functional language

Homebound or Hospitalized

Refers to children who are confined to the home or a hospital and must have instruction in that setting. May be long or short term, but must be at least three weeks.

Specific Learning Disabilities (SLD)

Evaluation by a psychologist, neurologist or other professional qualified to assess neurological dysfunction is required. All of the following characteristics must be present:

a) disorder in one or more of the basic psychological processes involved in understanding or in using spoken or written language, which disorder may manifest itself in imperfect ability to listen, think, speak, read, write, spell or do mathematical calculation

b) manifestation of symptoms characterized by diagnostic labels such as perceptual handicap, brain injury, minimal brain dysfunction, dyslexia or aphasia

c) development at less than the expected rate of age group in the cognitive, affective or psychomotor domains

d) inability to function in regular education without supportive special education services

e) unsatisfactory performance not found to be based on social, economic or cultural background

Severely Multiply Impaired (SXI)

A person identified by educational history, evaluation by a neurologist, orthopedic surgeon, opthalmologist, audiologist or equivalent, and other pertinent evaluators as having all of the following behavioral characteristics:

a) severe multiplicity of handicaps in the physical and cognitive domains

b) inability or expected inability to function within other special education programs which deal with a single handicap

c) development at less than the expected rate of age group in the cognitive, affective or psychomotor domains

WHAT YOU CAN EXPECT FROM THE SCHOOL DISTRICT

by Mary Wandschneider
and Helene Ginsberg

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WHAT YOU CAN EXPECT FROM THE SCHOOL DISTRICT

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Helene Ginsberg

Special Education Laws

There are two basic laws which affect special education. At the state level - "The Mandatory Special Education for the Handicapped Law" (P.A. 198, 1971). At the federal level - "The Education of all Handicapped Act of 1975" (P.L. 94-142).

State

Through the cooperative efforts of the parents, the schools, and organizations interested in handicapped children, Mandatory Special Education for the handicapped was made state law in 1971 by Public Act 198. The essence of the law can be summarized by the following statements:

1. Every handicapped child in Michigan has a right to a public school education of high quality; one that is designed to develop the child's maximum potential.
2. Regardless of the severity of handicap, an individual is entitled to an education from birth to age 25.
3. Decisions about program placement for handicapped children must be the result of a committee decision; this committee is known as the Educational Planning and Placement Committee (E.P.P.C.).
4. The parents of a handicapped child are members of the E.P.P.C. and have equal rights to participate in all decisions that affect the education of their child.
5. The parent has the right to legal procedures for resolving any differences between parent and school.
6. Parents have the right to see their child's school records.
7. Each intermediate school district must develop a comprehensive plan for the delivery of special education services.
8. A Parent Advisory Committee (PAC) made up of parents of handicapped children must be involved in the development of the intermediate school district's special education plan.

Federal

The Education of All Handicapped Children Act of 1975 (Public Law 94-142, Part B), contains the following provisions:

1. "A free appropriate public education will be available for all handicapped children between the ages of three and eighteen within the State, not later than September 1, 1980, except that with respect to handicapped children aged three to five and aged eighteen to twenty-one, inclusive, the requirements of this clause shall not be applied in any State if the application of such requirements would be inconsistent with State law or practice, or the order of any court, respecting public education within such age groups in the State." (Public Law (P.L.) 94-142, 1975, Section 612 (2) (B)).

2. Written Parent Permission: Must be obtained in order to do an individual assessment. The notice for permission must be in the native language of the home, or other mode of communication. If parents do not consent, the matter may be judged by a hearing officer.

3. Independent Evaluation: If parents question the results of an evaluation, they may solicit an independent evaluation by a qualified examiner at public expense. However, the school district is only responsible for payment if a hearing examiner determines the public evaluation to be invalid.

4. Re-evaluation: All students in special education are to be re-evaluated at least every three years, or more frequently if conditions warrant, or if the child's teacher or parent requests it.

5. Assessment Materials: Testing and evaluation materials and procedures used for the purpose of evaluation and placement must be selected and administered so as to be racially and culturally non-discriminatory. Students must be evaluated in all areas of the suspected disability, including health, vision, social and emotional status, intelligence, academic performance, communication status and motor ability. Assessment must be multi-disciplinary, i.e., involving more than one professionally responsible evaluator.

6. Physical Education: Physical education must be available to every handicapped student.

7. Least Restrictive Environment: Wherever appropriate, school districts must place handicapped students in a regular education program as close as possible to the child's home.

8. Individual Educational Plan (I.E.P.): Each handicapped student is to have an Individual Educational Plan which is updated each year.

9. Contents of the Individual Educational Plan: The federal rules require that the individual educational plan must include:

   a. A statement of the child's present level of educational performance;

   b. A statement of the annual goals including short term instructional objectives;

   c. A statement of the specific special education and related services to be provided to the child, and the extent to which the child will be able to participate in regular education programs;

   d. The projected date for initiation of services and the anticipated duration of service;

   e. Appropriate objective criteria and evaluation procedures and schedules for determining, on at least an annual basis, whether the short term instructional objectives are being achieved.

10. I.E.P. Meeting: Each school district operating special education programs and services is required to have a meeting to periodically review each child's individual educational program, and if appropriate, revise its provisions. The meeting must be held at least once a year. Each meeting shall include the following participants:

    a. A representative of the district, other than the child's teacher, who is qualified to provide, or supervise the provisions of special education;

    b. The child's teacher (special education and/or general education);

    c. One or both of the parents must be invited to attend the meeting;

    d. The child may be invited where appropriate;

e. Other individuals may be invited at the discretion of the parents or the agency.

(Items 2-9 adapted from Marvin E. Beekman Center, Lansing, MI, parent handout)

Special Education Procedures

Referring a Child for Evaluation for Special Education Services

The law states that a parent or any qualified professional can refer a child for evaluation for special education services. The school, once having received a referral, must receive parental permission before proceeding with any evaluation. The process for referral is for whoever is referring, including the parent, to write a letter to the local school superintendent requesting an evaluation. (See listing of local coordinators of Special Education in the Community Resources section of this handbook.)

Receiving Special Education Services

After a child has been evaluated and before any plans can be made for the child, the local school superintendent must appoint an Educational Planning and Placement Committee (E.P.P.C.). Within the next year there may be a change in the process as Michigan is attempting to combine the Michigan E.P.P.C. process with the federal Individual Educational Plan (I.E.P.) process, but much of what is described is likely to continue.

The members of the E.P.P.C. are: the parents of the child; a school administrator; a teacher; specialized diagnostic personnel certified in the suspected area of impairment; and anyone else the parent or school district would like to invite. The E.P.P.C. must:

1. Decide if the child is eligible for special education services by reviewing the information that is available about the child's problem.
2. Determine the program for the child, or change the existing program. (In this area, the elements of the program are listed on the E.P.P.C. form.)
3. Describe the goals for the child, and the program that will address those goals.

If the school system does not have an appropriate program for a particular child, it must provide one or contract with another school district to provide an appropriate program.

Resolving Problems About the Child's Education or Disagreeing with the Decision of the E.P.P.C.

If a parent is dissatisfied with the proposals set forth at the E.P.P.C., or with the educational options available for the child, he/she should first discuss the problem with the local coordinator of special education. (See listing of local coordinators and their phone numbers in the Community Resources section of this handbook.) A parent may also request, in writing, another E.P.P.C. If at this next E.P.P.C., the parent still disagrees, he/she should request, in writing, a formal hearing. (The hearing request is again directed to the local Coordinator of Special Education.)

A parent may also wish to contact local Parent Advisory Council (PAC) members for help with the procedures. The PAC consists of parents of handicapped children throughout the Intermediate School District (ISD) who meet with ISD administrators to share parent concerns. They also have legal responsibility for approving the local ISD yearly special education plan. (See the Community Resources section of this booklet for a listing of the Parent Advisory Council members.)

Given that a formal hearing may be considered, a few elements of the hearing are as follows:

1. It must take place between 15 and 30 days after the parent's request.
2. The parent must be given access to his child's school records.
3. The parent may bring to the hearing anyone he wishes.
4. The parent may require the attendance of any school personnel.
5. The parent may have the hearing closed to the public.

If the parent is not satisfied with the hearing decision, he may make another appeal to the State Superintendent of Public Instruction (Dr. Eugene Paslov, Acting Director, 517--373-3354) or the State Director of Special Education Services (Dr. Murray O. Batten, 517--373-1695).

(Above information on special education services has been gathered from Michigan Special Education Code (1977) and two Ingham Intermediate School District publications - Your Child's Right to an Education and A Parent Handbook of Special Education Services for the Handicapped Child (undated).)

Who Provides and Who Pays for Special Education Services?

In Michigan, both local districts and the intermediate school district provide special education services to children. The Intermediate School District pays (through taxes) for most special education services: however, federal, state, and local monies are also used. The Ingham Intermediate School District (IISD) consists of twelve communities and is part of several counties. (See attached map, figure 1.)

The IISD pays for approximately 65% of special education services, and the state pays approximately 35%. (Each ISD throughout the state has a different percentage match with the state.) Local districts may opt to add additional services and pay for these locally. Additionally, there are several small deferral grants for particular projects. The IISD receives its funds from an annual ISD property tax. (Voting for this ISD tax is separate from voting for a local school millage.) The IISD pays for services, but provides directly only a few. Furthermore, if a program is located in Lansing, it is administered by the Lansing School District; however, it is paid for by the state and the IISD. In addition to classroom programs, numerous supportive services are provided through special education. These services are also provided locally or contracted for and paid for by the same system as are the classroom programs.

In the summer, the IISD will only reimburse local school districts for programs that are mandatory in the summer (Severely Multiply Impaired and Severely Mentally Impaired). The state, however, will still contribute its 35% for whatever programs are provided. In addition, the IISD provides a percentage toward professional salaries as an incentive for the local school districts to provide summer programs for any group of children. The local districts must provide the remaining portion, and this sometimes means that parents pay tuition and provide transportation for their child who is in a summer program.

Special Education Preschool Programs in the Ingham Intermediate School District

There are numerous special education programs throughout the IISD. The following is a listing of preprimary programs: who is served, type of program, where located, and area served.

These programs include:

Figure 1: Ingham Intermediate School District map

Figure 2: Home Training Program for the Ingham Intermediate School District

Figure 3: Home Training Program for the Lansing Area

Figure 4: Okemos Pre-Kindergarten Center

Figure 5: Pinecrest Elementary School Auditory/Oral Program for the Hearing Impaired - Preschool Classroom

Figure 6: North School - Preprimary Hearing Impaired Program

Figure 7: Ingham Intermediate School District Infant Program for the Visually Impaired

Figure 8: North School - Preprimary Physically and Otherwise Health Impaired Programs

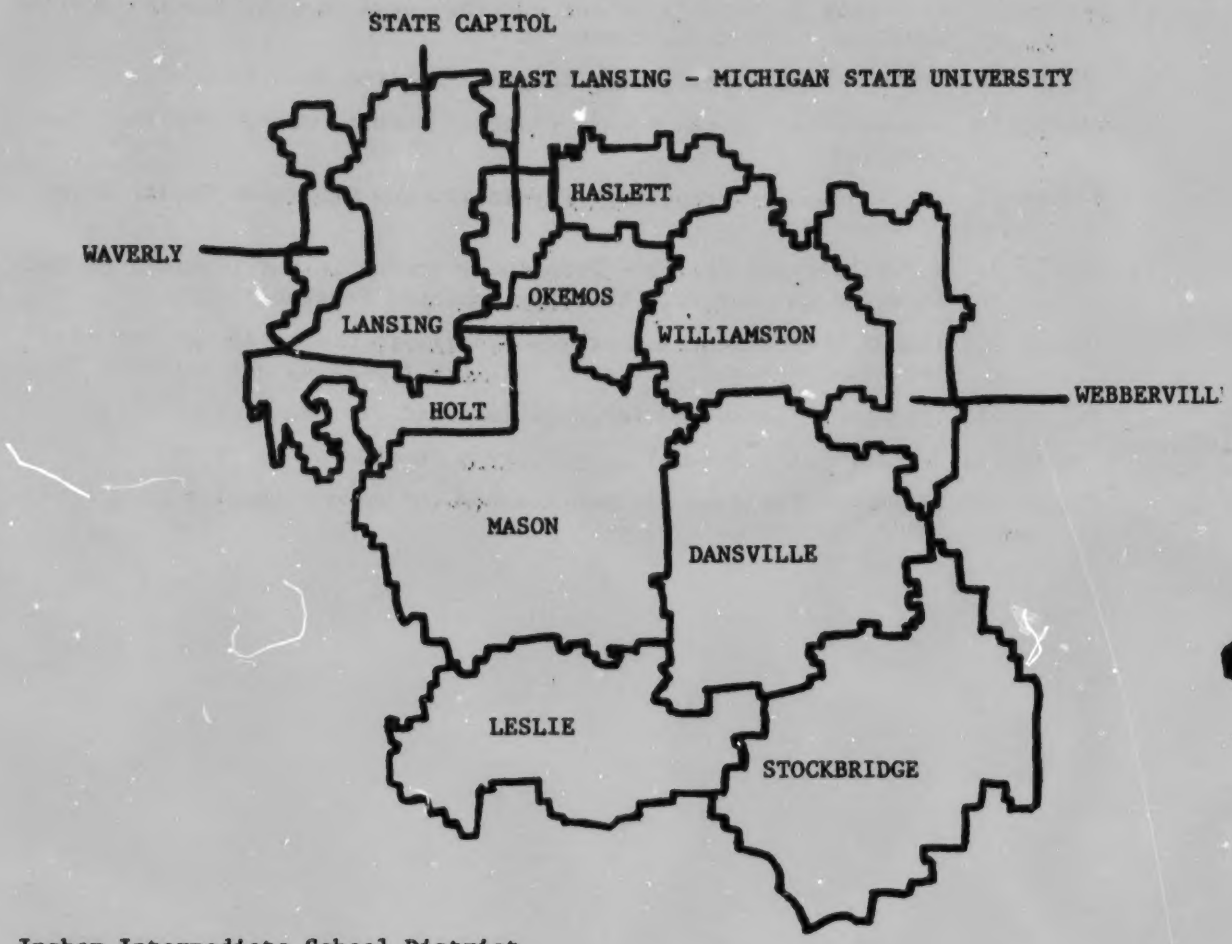
Figure 9: Marvin Beekman Center - Preprimary Trainable and Severely Mentally Impaired and Severely Multiply Impaired Programs

Figure 10: Ingham Developmental Center - Preprimary Trainable and Severely Mentally Impaired, Severely Multiply Impaired, and Autistic Programs

Figure 11: Preschool Speech and Language Impaired Program

Figure 12: Developmental Disabilities Program outside of Lansing

Figure 13: Preschool Programs for Handicapped Children - Lansing Area Developmental Program



Ingham Intermediate School District
Approximate total membership - 64,000

FIGURE 1: INGHAM INTERMEDIATE SCHOOL DISTRICT MAP

WHO IS SERVED	This program serves handicapped or potentially handicapped children between the ages of 0 and 4 who are in need of a training program in the home. These may be children who are identified early as needing special programming or those suspected of being in need of a home stimulation and intervention program.
TYPE OF PROGRAM	There is an emphasis on evaluation and meeting immediate concerns of the family. This often means involving other areas of specialties such as the occupational therapist, physical therapist, school nurse, psychologist, etc. The focus of the program will be on the development of speech and language skills appropriate to the child's age. The home training specialist is a speech and language pathologist with the American Speech and Hearing Association's Certificate of Clinical Competence in Speech Pathology, and certified to teach children with learning disabilities.
AREA SERVED	The program is available to all residents of the Ingham Intermediate School District outside Lansing.
FOR FURTHER INFORMATION, PLEASE CONTACT	Kenneth J. Woodring Special Education Supervisor INGHAM INTERMEDIATE SCHOOL DISTRICT 2630 West Howell Road Mason, Michigan 48854 Telephone: 676-2481

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FIGURE 2: HOME TRAINING PROGRAM FOR THE INGHAM INTERMEDIATE SCHOOL DISTRICT

WHO IS SERVED	This program serves handicapped or potentially handicapped children between the ages of 0 and 4 who are in need of a training program in the home. These may be children who are identified early as needing special programming or those suspected of being in need of a home stimulation and intervention program.
TYPE OF PROGRAM	There is an emphasis on evaluation and meeting immediate concerns of the family. This often means involving other specialty areas such as the occupational therapist, physical therapist, school nurse, psychologist, etc. The focus of the program will be on the development of speech and language skills appropriate to the child's age. The home training specialist is certified in special education.
AREA SERVED	Residents of the Lansing School District.
FOR FURTHER INFORMATION, PLEAST CONTACT	Velma Allen Lansing Special Education 519 West Kalamazoo Lansing, MI 48933 Telephone: 374-4000

FIGURE 3: HOME TRAINING PROGRAM FOR THE LANSING AREA

WHO IS SERVED

Children between the ages of approximately 3 and 6 whose developmental problems are severe enough to require an individualized program providing clinical as well as educational intervention for child and family.

1. Children with severe language deficits which may be the result of emotional problems.
2. Children with severe behavior problems which result in inappropriate relationships with peers, siblings or adults.
3. Enigmatic children whose learning and adjustment problems require careful and/or prolonged study by a clinical-educational team.

TYPE OF PROGRAM

1. Up to one-half day instructional program.
2. Individual, group and family therapy as indicated.
3. Staff

   Full-time educational staff:
   a. Director/teacher approved to teach in special education
   b. Certified teacher approved to teach in special education

   Diagnostic, consulting and treatment staff
   a. Certified consulting psychologist
   b. Speech and language therapist
   c. School social worker
   d. Specialists in play therapy and family therapy

AREA SERVED

The program is available to all residents of the Ingham Intermediate School District.

FOR FURTHER INFORMATION, PLEASE CONTACT

Mr. William Wilcox
Okemos Pre-Kindergarten Center
Central School
Okemos, MI 48864
Telephone: 349-4898

FIGURE 4: OKEMOS PRE-KINDERGARTEN CENTER

WHO IS SERVED	Preschool children (from 2½ years) who are determined to be hearing impaired and would best benefit from an auditory/oral approach to teaching hearing impaired children.
TYPE OF PROGRAM	1. One-half day program several times a week. 2. Certified teacher in special education. 3. Emphasis placed on: - language developed through the use of speech and audition. - home training weekly with parents for parent counseling/education, demonstration teaching, and carry-over of classroom teaching concepts and techniques.
WHERE	Pinecrest Elemtary School 1811 Pinecrest Drive East Lansing, MI 48823
FOR FURTHER INFORMATION, PLEASE CONTACT	Gary Davis, Director Special Services Department East Lansing Public Schools 509 Burcham Drive East Lansing, MI 48823 Telephone: 337-1781

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FIGURE 5: PINECREST ELEMENTARY SCHOOL AUDITORY/ORAL PROGRAM FOR THE HEARING IMPAIRED - PRESCHOOL CLASSROOM

WHO IS SERVED	Children up to the age of 6 years who are determined to be hearing impaired and who would benefit from a total communication approach to teaching hearing impaired children.
TYPE OF PROGRAM	1. One-half day program. 2. Certified teacher in special education. 3. Emphasis placed on: - academic readiness - socialization - total communication learning - supplement speech and hearing training with sign language and finger spelling. 4. Home training program for children under 2½ and weekly home visits with children in school program.
WHERE	North School 333 East Miller Road Lansing, MI 48910
FOR FURTHER INFORMATION, PLEASE CONTACT	Bob Weir, Coordinator Deaf and Hard of Hearing Program 333 East Miller Road Lansing, MI 48910 Telephone: 374-4586

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FIGURE 6: NORTH SCHOOL PREPRIMARY HEARING IMPAIRED PROGRAM

WHO IS SERVED	Preschool children who are determined to be visually impaired within the entire Ingham Intermediate School District.
TYPE OF PROCRAM	1. One-half day program for children 2½ years through preschool, and a weekly home teaching session. 2. Home training program for children under 2½ years. 3. Certified teachers. 4. Emphasis placed on: - "life skill curriculum" - the real environment of the child which includes such aspects as eating, food preparation, dressing, self-care learning, independent movement, physical mobility and orientation, meaningful language development and communication skills, and self and environmental awareness.
WHERE	Walnut Street School 1012 N. Walnut Street Lansing, MI 48933
FOR FURTHER INFORMATION, PLEASE CONTACT	Kenneth J. Woodring, Special Assistant Ingham Intermediate School District 2630 West Howell Road Mason, MI 48854

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FIGURE 7: INGHAM INTERMEDIATE SCHOOL DISTRICT INFANT PROGRAM FOR THE VISUALLY IMPAIRED

WHO IS SERVED	Children between the ages of approximately 2½ and 6 years who are determined to be physically and otherwise health impaired within the entire Ingham Intermediate School District.
TYPE OF PROGRAM	1. One-half day program. 2. Certified teacher in special education. 3. Emphasis placed on: - academic readiness - socialization - heavy emphasis on physical and occupational therapy.
WHERE	North School 333 East Miller Road Lansing, MI 48910
FOR FURTHER INFORMATION, PLEASE CONTACT	Dawn Dicky 333 East Miller Road Lansing, MI 48910 Telephone: 374-4586

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FIGURE 8: NORTH SCHOOL PREPRIMARY PHYSICALLY AND OTHERWISE HEALTH IMPAIRED PROGRAM

WHO IS SERVED	Children under the approximate age of 6 years who are determined to be trainable and severely mentally impaired, (TMI and SMI) and severely multiply impaired (SXI) (in a school which serves children with these handicaps to the age of 26 years.) Serves children from Lansing and Waverly School Districts.
TYPE OF PROGRAM	1. Offers full-day program five days weekly, can arrange for part-week or part-day. 2. Certified teachers in special education. 3. Emphasis placed on individualized program; some general considerations: - SMI, TMI, and some SXI children self care - SXI children - physical and occupational therapy as needed - speech and language development - development of gross and fine motor skills - concept learning as appropriate 4. Home training program for children under about 3 years.
SUMMER PROGRAM	SXI and SMI children receive a full-time summer program.
WHERE	Marvin Beekman Center 2901 Wabash Road Lansing, MI 48910
FOR FURTHER INFORMATION, PLEASE CONTACT	Donald Kopec Marvin Beekman Center 2901 Wabash Road Lansing, MI 48910 Telephone: 374-4900

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FIGURE 9: MARVIN BEEKMAN CENTER PREPRIMARY TRAINABLE AND SEVERELY MENTALLY IMPAIRED AND SEVERELY MULTIPLY IMPAIRED PROGRAMS

WHO IS SERVED	Children between the ages of approximately 3 and 6 years who are determined to be: trainable and severely mentally impaired (TMI, SMI), severely multiply impaired (SXI), and autistic preschool children (in a school which serves children with these handicaps to the age of 26 years). Serving all autistic children within the entire IISD, and serving children within the entire IISD outside Lansing.
TYPE OF PROGRAM	1. Offers full-day program 5 days weekly, can arrange for part-week or part-day. 2. Certified teachers in special education. 3. Emphasis placed on: - self care for SMI, TMI, and some SXI children - SXI children - physical and occupational therapy as needed - speech and language development - development of gross and fine motor skills - concept learning as appropriate
SUMMER PROGRAM	SXI and SMI children receive a full-time summer program. TMI children may receive a summer program. (This is not mandated and therefore is offered on the basis of available finances.)
WHERE	Ingham Developmental Center 2630 West Howell Road Mason, MI 48854
FOR FURTHER INFORMATION, PLEASE CONTACT	David Fuller, Principal Ingham Developmental Center 2630 West Howell Road Mason, MI 48854

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FIGURE 10: INGHAM DEVELOPMENTAL CENTER PREPRIMARY TRAINABLE AND SEVERELY MENTALLY IMPAIRED, SEVERELY MULTIPLY IMPAIRED, AND AUTISTIC PROGRAMS

WHO IS SERVED	Children for whom it is determined that speech and language difficulties are their primary disability. (Program begins at approximately 3 years and may continue until a child enters kindergarten.) Serves children in the Lansing School District.
TYPE OF PROGRAM	1. Half-day program, varying number of days commensurate with the child's needs. 2. Parent participation and cooperation vital in the classroom and at home. 3. Emphasis placed on: - a preschool program in which everything is geared to speech and language development - e.g., particular listening times - all children also receive individual speech therapy
WHERE	Fairview School 815 North Fairview Lansing, MI
FOR MORE INFORMATION, PLEASE CONTACT	Doris Konrad Special Education/Speech Therapy Office of the Coordinator Lansing, MI Telephone: 374-4285

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FIGURE 11: PRESCHOOL SPEECH AND LANGUAGE IMPAIRED PROGRAM

WHO IS SERVED	Children between the ages of approximately 3 and 6 years who are handicapped or potentially handicapped in the cognitive areas: 1. Children having serious delay and/or disorders in speech and language development 2. Children suspected as being moderately or mildly mentally handicapped 3. Children who will have severe learning problems
TYPE OF PROGRAM	1. One-half day program 2. Staff: certified teacher in special education. Assisted by: Speech and Language Therapist, School Psychologist, Teacher Consultant for physically handicapped, School Social Worker, other school specialists. 3. Emphasis placed on: - speech and language development - development of gross and fine motor skills - preschool activities - diagnostic therapy
WHERE	Haslett Developmental Disabilities Classroom Murphy Elementary School 1875 Lake Lansing Road, Haslett 48840 serving children within the East Lansing, Haslett, Okemos, Williamston, and Webberville Districts
	Mason Developmental Disabilities Classroom Cedar Street Elementary School 400 S. Cedar Street, Mason 48854 serving children within the Leslie, Dansville, and Mason School Districts
	Holt Developmental Disabilities Classroom Sycamore Elementary School 4429 Sycamore Street, Holt 48842 serving children within the Holt and Waverly School Districts
	Stockbridge Developmental Classroom Gregory Elementary School 126 Webb Street Gregory, MI 48137 serving children within Gregory, Munith and Stockbridge School Districts
FOR FURTHER INFORMATION, PLEASE CONTACT	Kenneth J. Woodring, Special Assistant Ingham Intermediate School District 2630 West Howell Road Mason, MI 48854 Telephone: 676-1051

FIGURE 12: DEVELOPMENTAL DISABILITIES PROGRAM OUTSIDE OF LANSING

WHO IS SERVED	Children within the Lansing School District between the ages of approximately 3 and 6 years who are handicapped or potentially handicapped in the following areas: 1. Children having serious delay and/or disorders in speech and language development. 2. Children suspected as being moderately or mildly mentally handicapped. 3. Children who will have severe learning problems. 4. Children suspected as being moderately or mildly emotionally handicapped.
TYPE OF PROGRAM	1. One-half day program 2. Staff: Certified teacher in special education Assisted by: Speech and Language Therapist, School Psychologist, Teacher Consultant for physically handicapped, School Social Worker, other school specialists 3. Emphasis placed on individualized program considering areas such as: - speech and language development - development of gross and fine motor skills - preschool activities - diagnostic therapy 4. Home training program for children under about 3 years.
WHERE	Five elementary schools throughout Lansing School District; the locations may change year to year.
FOR FURTHER INFORMATION, PLEASE CONTACT	Edna Felmlee 519 W. Kalamazoo Street Lansing, MI 48933 Telephone: 374-4264

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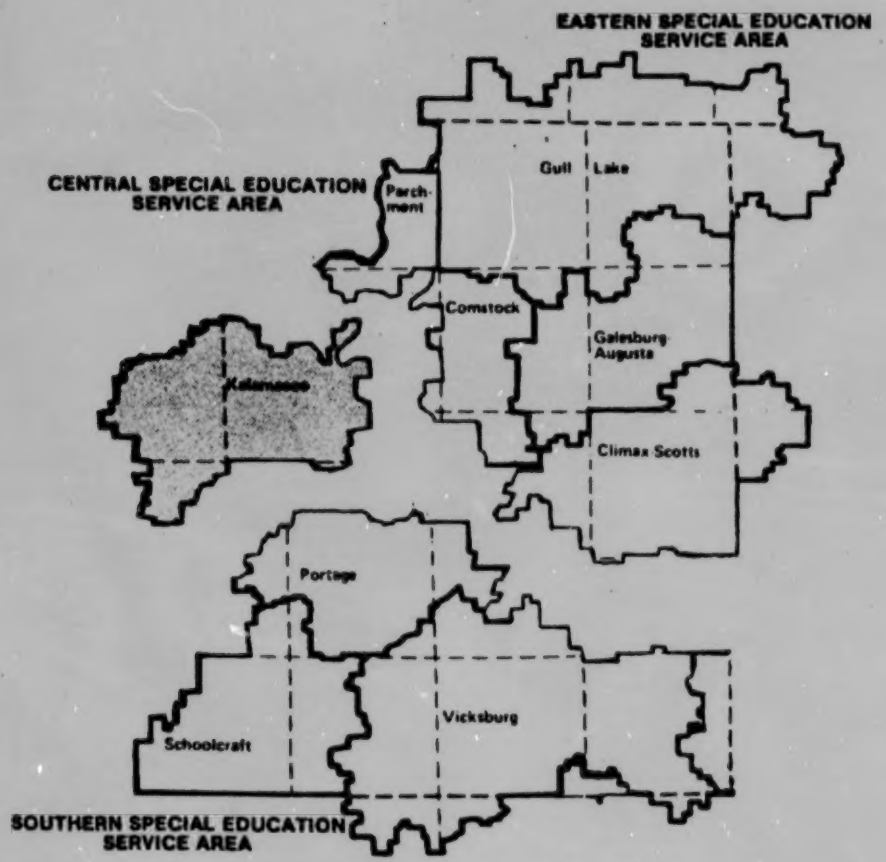
FIGURE 13: PRESCHOOL PROGRAMS FOR HANDICAPPED CHILDREN
LANSING AREA DEVELOPMENTAL PROGRAM

Special Education Preschool Programs in the Kalamazoo Valley Intermediate School District

The PATHWAYS Project provided an outreach project in the greater Kalamazoo area during the 1978 to 1979 school year. A number of the handicapped children in the project have also received services from the local and intermediate school districts. The following is a map of the Kalamazoo Intermediate School District (Figure 14) and a listing of the preprimary special education programs within the Kalamazoo Intermediate School District (Figure 15).



Map taken from: Special Education Programs and Services: A Handbook for Parents by Parents, by the Kalamazoo Valley Intermediate School District

FIGURE 14: KALAMAZOO VALLEY INTERMEDIATE SCHOOL DISTRICT

Area Served	Program	Staff
KVISD	Preprimary Evaluation and Training Project (P.E.T.) Evaluation Component Infant Training Component - A.M. Infant Training Component - P.M. Croyden Avenue School	Coordinator and Social Worker - Charley Burkett (contact person) Ph. 381-4620 ext. 281 School Psychologist - Susi Selinsky Teacher - Ellen Vreeland O.T. - Donna Spanhak P.T. - Pam Simpson Teacher of Speech and Language - Earl Horn Case Coordinators - Noreen Jolliffe, Mary Forrester, and Edie Clompus
KVISD	Kalamazoo Valley Multihandicap Center Croyden Avenue School	Coordinator - Jerry Shook School Psychologist - Chris Blakeman (contact person) 381-4620 ext. 221 Instructional Leaders - I. Nancy Wojciechowski and II. Michelle Polver Component Coordinators - I. Rhoda Yutzy and Tom Bell II. Tom Rieber and Cassie Braan Ancilliary Staff: Sharon Roberts, Pam Simpson, Earl Horn, and Jeannie Meyer
KVISD	Severely Mentally Impaired Program Croyden Avenue School	Coordinators - Ellen Thompson and Lestra Hazel, x219 Instructional Specialist (Primary Pod A) - Rick Branch Classroom Leader - JoAnn DeGrush P.T. - Carolyn Dixon O.T. - Coby Backoff Speech Therapist - Dick Wills
KVISD	Hearing Impaired Nursery Milwood Elementary School	Consultant - Sandy Ball (contact person) 385-0927 Principal - Carl Czuchna Teacher - Jan McDonald

FIGURE 15: SPECIAL EDUCATION PREPRIMARY PROGRAMS WITHIN THE KALAMAZOO VALLEY INTERMEDIATE SCHOOL DISTRICT

Area Served	Program	Staff
KVISD-if mentally impaired; Kalamazoo-if other handicap	Developmental Preschool ....at Parkwood/Upjohn ....at Milwood Elementary	Consultant - Nancy Todd (contact person) 385-0975 Program Specialist - Marian Ross Teacher - Peg Lavender (Upjohn) Teacher - Mary Foshey (Milwood) Teacher - Nancy Pawlowski (Milwood)
KVISD	Program for Physically and Otherwise Health Impaired ....Early Intervention Program (0-3) Parkwood-Upjohn School ....Upjohn Nursery (3-5) (A.M. & P.M.) Parkwood Upjohn School	Program Specialist - Dee Carney Consultant - Doris Hamill (contact person) 385-0921 Teacher - Helen Hinman P.T. - Nancy Diment O.T. - Sarah Meyer Speech Therapist - Anita Bischoff Teacher - Dick VanderWeyden
KVISD	Consultant Services (381-4620) ... for Hearing Impaired ... for Visually Impaired	 Doreen Walton George Ossentjuk, Carol Ducyyminski, Jeanne Strobl
Southern Service Area of KVISD	Portage Preprimary Learning Disabilities Classroom Waylee Elementary School	Teacher - Jeannie White Contact - Flora Mendoza 327-3081
Eastern Service Area of KVISD	Richland Preprimary Learning Disabilities Classroom Wildermuth Elementary School	Consultant - Joan Francisco (contact person) Principal - John Grace Teacher - Barbara Cooper/Virginia Hartline
Eastern Service Area of KVISD	Comstock Preprimary Speech and Language Program, West Elementary School	Teacher - Shirley Eccles Contact - John Engle 385-2008
Local Districts	Individual Speech Therapy	Speech therapists at local schools (contact local Special Education Director)

(revised May, 1979)

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FIGURE 15 (CONTINUED)

Support Services From the Ingham Intermediate School District (IISD) to Private Preprimary Programs

In addition to specific preprimary special education programs, the IISD has outlined some services as permissible in the support of handicapped children mainstreamed/integrated into non-public school preschool programs. (These children may also be in a special education preschool program part of the day.) Primarily, the IISD will provide a teacher consultant to work with the handicapped child and the preschool staff. The responsibility of suggesting the integration/mainstreaming option is up to the parents at an Educational Planning and Placement Committee (E.P.P.C.) meeting. The Ingham Intermediate School District will provide consultants to private programs in which a handicapped child is mainstreamed when (and only when) this is designated at the E.P.P.C. meeting and listed on the E.P.P.C. form.

The consultant could provide the following support services to the preschool staff:

- information on handicapping conditions
- information of appropriate teaching strategies and curriculum ideas
- modeling of intervention, interaction and stimulation techniques
- reading resources (books, materials, etc.) on handicapping conditions and early childhood programming loaned to the preschool
- invitation to community preschool teachers to relevant IISD workshops

Information on Laws and Legal Rights of Handicapped Children
An Annotated Bibliography, 1979

1. Copy of P.A. 198 (State) Mandatory Special Education Law of 1971

   from: Legislative Service Bureau
   123 W. Allegan
   Lansing, MI 48913
   517—373-0170

   The special education law of Michigan - very general.

2. Copy of P.L. 94-142 (Federal) Education for All Handicapped Children Act of 1975, Regulations

   from: your congress person (free)
   or
   Superintendent of Documents
   U.S. Government Printing Office
   Washington, D.C. 20402
   (45¢ per copy)

   The federal special education law - very specific.

3. Michigan Special Education Code (1977) under provisions of P.A. 198

   from: Michigan Department of Education
   Special Education Services Area
   P.O.Box 420
   Lansing, MI 48902
   517—373-9023

   The specifics of the state special education law; e.g., ratios of children to teachers, eligibility for services, definitions of handicapping conditions etc.

4. Booklets explaining: P.A. 198 and P.L. 94-142

   from: State Department of Education - Special Education Services
   (see above for address)

5. Booklet with further explanation of 94-142 and Section 504 regulations:

   from: Children's Defense Fund
   1520 New Hampshire Avenue, N.W.
   Washington, D.C. 20036

6. Pamphlets: Your Child's Right to an Education and A Parent Handbook of Special Education Services for the Handicapped Child

   from: Ingham Intermediate School District
   Division of Special Education
   2630 West Howell Road
   Mason, MI 48854
   517--676-1051

   Explanation of the state law and federal laws and services available.

7. How to Organize an Effective Parent Group and Move Bureaucracies

   from: Coordinating Council for Handicapped Children
   407 S. Dearborn Street
   Room 680
   Chicago, IL 60605
   Cost: $1.50 - make checks payable to: Coordinating Council for Handicapped Children

ANNOTATED COMMUNITY RESOURCES

by Mary Wandschneider and Helene Ginsberg

Following is a listing of resources which provide supportive services to handicapped children, their families, and agencies who work with handicapped children. Location, contact person, and services provided are listed for each agency. The following categories are included:

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ANNOTATED COMMUNITY RESOURCES

by Mary Wandschneider and Helene Ginsberg

GREATER LANSING AREA

Agencies Which Have Referred Handicapped (or High Risk) Children for Possible Integration/Mainstreaming into Community Preschools:

Developmental Assessment Clinic - Sparrow Hospital, Sister Mary Christine Kramin, Social Worker, Dawn Welch, Physical Therapist, 1215 E. Michigan Ave., Box 30480, Lansing, MI 48909 Phone: 487-6111

Periodically assesses children who have spent time in Sparrow Hospital's Neonatal Intensive Care Unit. Also assesses other children upon referral.

Family and Child Services (Capitol Area United Way), Elmer Arnesam, Director, 300 N. Washington Ave., Room 102, Lansing, MI 48933 Phone: 484-4455

Experienced, professionally trained staff is available to provide services in the following areas: marital problems, parent-child problems and personal problems, money management, social adjustment and career adjustment problems, problem pregnancy, recruitment and licensing of the foster homes, foster care, and adoption. Individual and group counseling available.

Head Start (Capitol Area Community Services), Tom Hopkins, Special Needs Coordinator, 101 E. Willow, Lansing, MI 48996 Phone: 482-1504, ext. 6

14 preschool centers located in Ingham, Clinton, Eaton and Shiawassee counties serving low income 3-5 years olds, and any income level handicapped children.

North School, Bob Weir, Mary Gruman, William Johnson, Mildred White, Patty Hassenger, Debbie Lempicki, Brenda Hull, Judy Clark, 333 E. Miller Road, Lansing, MI 48910 Phone: 374-4586

Neighborhood elementary school which also serves, and often integrates/mainstreams hearing impaired and physically and otherwise health impaired children from throughout the Ingham Intermediate School District. Also has a preschool program for the handicapped children.

Protective Services (Ingham County), Barbara Walkington, George Duncan, 930 N. Holmes Road, Lansing, MI 48910 Phone: 373-6938

Serves children who are experiencing abuse or neglect in their home, foster home, or institution. Services are available regardless of income level and are provided to families and children around the clock.

Child Care

Office for Young Children, Mark Sullivan, 403 W. Greenlawn, Lansing, MI 48910 Phone: 371-5360

Provides information concerning child care centers and children's services, referrals and consultation that relates to children, education and training for those who work with children. Has developed a series of publications available at cost. Open to the public, no fee, call or visit for information.

Family Counseling

Catholic Social Services, contact intake worker for the day, 300 N. Washington, Lansing, MI 48933 Phone: 372-4020

Provides individual, family, marital and group counseling. Open to public, serves all faiths. Fee on a sliding scale based on ability to pay. Call for an appointment.

Equal Ground, 415 Park Lane, East Lansing, MI 48823 Phone: 337-1661

Provides family counseling for status offenders (person under age 17 who is a runaway, truant, violates curfew) and their families. Also provides temporary foster care for adolescents. Open to the public, no fee; call or visit.

Family and Child Services, Mrs. Heater, 300 N. Washington, Lansing, MI 48933 Phone: 484-4455

Provides counseling for families on a group, partial group, or one-to-one basis. Open to the public, sliding scale fee based on ability to pay, call for appointment.

Family Life Referral Clinic - M.S.U., Corrie Hohly, B101 Fee Hall, M.S.U., East Lansing, MI 48824 Phone: 355-5763

Provides counseling to families; uses conjoint family therapy approach. Open to public September to May, sliding scale fee based on ability to pay, call for an appointment.

Family Planning, 701 N. Logan, Suite 430, Lansing, MI 48914 Phone: 372-9212

Provides medical and educational service for family planning. Primary concern is for the health of the mother: physical, mental, emotional, and social. All birth control and counseling is aimed at this goal. Open to the public - priority given to those of high risk, access, or limited income. No fee, appointments may be scheduled Monday-Friday, 8 a.m. to 5 p.m.

Tri-County Mental Health, Charlotte Laderoute, 300 N. Washington, Lansing, MI 48933 Phone: 374-8000

Provides programs for mentally retarded, comprehensive substance abuse programs, individual and family counseling, child and adolescent services. These programs are offered at various locations determined by service and residence of persons receiving services. Locations include:

Community Mental Health Bd., Clinton-Eaton-Ingham, 300 N. Washington Square, Lansing, MI 48933

Lincoln Center for Emotionally Disturbed Children, 403 W. Greenlawn, Lansing, MI 48910

Programs for Mentally Retarded, 835 Louisa Street, Lansing, MI 48910

Mason Mental Health, 157 W. Maple, Mason, MI 48854

St. Lawrence Community Mental Health, 1201 W. Oakland, Lansing, MI 48915

Comprehensive Substance Abuse Treatment Program, 300 N. Washington, Lansing, MI 48933

Must be Tri-County residents, fee is sliding scale based on ability to pay, call for referral to appropriate program.

Handicaps in General

Citizen Advocacy Program, Patricia Litwhiler, Coordinator, 855 Grove Street, East Lansing, MI 48823 Phone: 351-9592

This program provides assistance to developmentally disabled persons in the area where these citizens may not be well represented. Volunteers (Advocates) are matched with handicapped persons (proteges) on a one-to-one basis for a mutually rewarding relationship. The Advocate safeguards the protege's interests and makes certain he receives all the benefits and services to which he is entitled.

Council for Exceptional Children - local chapter, David Fuller, Secretary, 2630 W. Howell Road, Mason, MI 48854, Phone: 676-1051

Local chapter of a national organization - advocacy and information group. National organization publishes the following journals: Exceptional Children, and Teaching Exceptional Children.

Information and Referral Service, Vincent J. Kuntz, Director, 300 North Washington, Lansing, MI 48914, Phone: 372-8550

Information and Referral Service is a central office service of the United Community Chest of Ingham County. A hot line for people who need help and don't know where to look. It tries to get people in contact with appropriate services and assists them in getting satisfactory help. It serves all persons calling for assistance of any kind.

Ingham County Health Department, George Dellaportas, M.D., Director, 403 W. Greenlawn, Lansing, MI 48910, Phone: 371-5360

A public agency serving all ages and disabilities. It provides services such as counseling, information and referral, education, speakers, publications, nursing, medical and dental health screening and treatment services, immunization clinic.

Ingham Intermediate School District, Special Education Division, David L. Haarer, Ph.D., Assistant Superintendent of Special Education, 2630 W. Howell Road, Mason, MI 48854, Phone: 676-1051

Any child between the ages of 0-25 deemed to be handicapped and residing within the Ingham Intermediate School District is eligible. Services offered are special education classes for mentally impaired; emotionally impaired; physically impaired; deaf and hard of hearing; blind and partially sighted; learning disabled. Support services are provided by teacher/consultants for the physically or otherwise health impaired (includes acoustically and visually impaired); teachers of speech and language impaired; school psychologists; homebound teachers; physical therapists; occupational therapists; school social workers.

March of Dimes - Ingham County Chapter, Mrs. Robert Yelvington, Executive Secretary, 209 N. Seymore, Lansing, MI 48933, Phone: 482-1249

The purpose of this organization is to supply educational materials on birth defects. The organization currently serves as a clearinghouse for other agencies because of its extensive referral system. Services provided are counseling, group therapy, information and referral, education, rehabilitation, transportation, financial assistance, medical examination, medical supplies, research, occupational therapy, physical therapy, speakers, publications, nursing, medical treatment, and prenatal clinics.

Michigan Department of Education, Special Education Services, Murray O. Batten, Director, P.O.Box 420, Lansing, MI 48902, Phone: 373-0923

As one division of the Michigan Department of Education, the Special Education Services area has responsibility for all special education programs in the state. Consultants can assist you and act to answer your questions concerning educational matters in any area of special education.

Michigan Department of Mental Health, Donald C. Smith, M.D., Acting Director, Lewis Cass Building, Lansing, MI 48913, Phone: 373-3740

The Michigan Department of Mental Health provides mental health services for the mentally retarded and the mentally ill within the State of Michigan.

Services are provided through institutional and community mental health programs. Services provided by local boards are out-patient services, partial hospitalization, in-patient services, mental health education, and mental health consultation. Specific services include psychological services, counseling, group therapy, education, recreation, rehabilitation, day care, social activity, professional materials, library services, vocational training, sheltered work, physical examination, medical treatment, psychiatric services, occupational therapy, physical therapy, speech therapy, transportation, publications, film loan, research, legislative activity, other.

Michigan State Genetics Clinic, Department of Human Development, B240 Life Science Building, M.S.U., East Lansing, MI 48824

Offers genetic counseling and testing to adults and children.

Williamston Center for Human Development, Thomas Mead, Director, P.O.Box 8, Williamston, MI 48895, Phone: 655-1614

An evaluation and programming center for children with minimal to severe neurological dysfunctions, learning disabilities, cerebral palsy, mental retardation. Offers a home therapeutic program.

WISH, Women in Service to the Handicapped, Mrs. Lee Worthington, Chairman, Phone: 332-1330

Designed to provide more rapid and improved means of service for handicapped individuals in the area.

Health Services

Audiology and Speech Clinic, Audiology and Speech Science Building, M.S.U., East Lansing, MI 48824, Phone: 353-8780

Assesses child's hearing ability. Has speech and hearing therapy available.

Clinical Center, M.S.U., Service Road, East Lansing, MI 48824 Phone: 353-3000

Provides general medical care for the whole family with focus on prevention and health maintenance. Free child care for clients. Open to the public, fee varies. Hours are from 8 a.m. to 5 p.m., Monday through Friday; call for an appointment.

Community Health Services, Ann Gillette, 701 N. Logan, Lansing, MI 48915 Phone: 482-1405

Provides general medical care for adults and children by appointment, and V.D. diagnosis and treatment on a walk-in basis during those clinic hours. Open to the public, no fee, call for clinic hours.

DEC, Inc., 398 Park Lane, East Lansing, MI 48823, Phone: 351-4000

The DEC offers non-emergency care: V.D. testing, diagnosis, and a pediatric clinic that provides physicals, and well child care. Open to the public, no fee, call for clinic hours.

Developmental Assessment Clinic, Medical Social Services, Sparrow Hospital, Box 30480, 1215 E. Michigan Ave., Lansing, MI 48909

Assesses children suspected to be delayed in any area of development. Refers families to appropriate services.

Health Central, 2316 S. Cedar, Lansing, MI Phone: 374-6600

Vision screening, well-baby care, pre and post natal care, and nutrition counseling as well as other health care services are available for Health Central enrollees. Open to anyone who wishes to become a member. Membership fee on a monthly basis, call for appointment.

Ingham County Health Department, 403 W. Greenlawn, Lansing, MI 48910, Phone: 371-5360

The following services are provided by the Health Department:
- free immunizations at various locations
- vision and hearing screening
- blood pressure screening
- public health nurses available for health counseling
- March of Dimes prenatal clinic; call 482-1249 for appointment

Open to the public, no fee, call for hours

Ingham County Health Department Dental Clinic, 403 W. Greenlawn, Lansing, MI 48910 Phone: 371-5360 ext. 301

The clinic provides routine and emergency dental care. Hygienist will visit schools. Services provided for residents of Ingham County - appointment only. Sliding scale based on ability to pay fee, services provided by appointment only; call to be placed on waiting list.

Ingham County Project Health, 701 N. Logan, Lansing, MI 48915, Phone: 489-7511
Contact Clinic Coordinator, Deanna Kramp, RN

Provides health screening for medicaid recipients under age 21. For appointment contact Jan Schaffer, Department of Social Services, 373-6934. No fee for medicaid recipients; do not accept non-medicaids.

Lansing Community College Dental Hygiene Clinic, Natural Arts and Science Bldg., 419 Capitol, Lansing, MI Phone: 373-7189

The clinic provides dental cleaning, x-ray, and flouride treatment performed by junior and senior students. Open to the public, Fees are inexpensive, and are posted at the clinic. Must visit to make an appointment and be placed on waiting list.

Ingham Intermediate School District

Assistants in Special Education

These Special Assistants to the Director of Special Education have responsibility for helping to develop good programming for your child throughout the intermediate district. Each person has some particular area of service in which he specializes. These people are directly available to you. If you have a question that is not appropriate for any specific school district, you might try the intermediate office. The main phone number is 676-1051.

Program Area	Person
Speech and Language Impaired	Ken Woodring
Severely Multiply Impaired	
Mentally Impaired	
Physically and Otherwise Health Impaired	
Hearing Impaired	
Visually Impaired	
Hospitalized	

Program Area	Person
Learning Disability Emotionally Impaired	Dr. Helen Romsek
Director of Special Education	Dr. David L. Haarer (You may want to call this person if your problem does not fit into any of the above program areas.)

Local Coordinators of Special Education - IISD

These individuals are designated by local school systems to insure proper special education programs are planned for your child. They would be a good place to start your inquiry.

Dansville	Larry Cook	623-6182
East Lansing	Gary Davis	337-1781
Haslett	Gunnard Johnson	339-8208
Holt	George Zarka	694-2442
Lansing	Velma Allen	374-4300
Leslie	Robert Geer	589-8294
Mason	Heather Sellick	676-2484
Okemos	Bill Wilcox	349-9220
Stockbridge	James Hatch	(313)498-2883
Waverly	JoAnn Carlisle	321-7265
Webberville	Bernard Curtis	521-3071
Williamston	John Pixley	655-2855

Parent Advisory Committee for Special Education (PAC) - IISD

These individuals have been selected by their local school district administration and appointed to the Parent Advisory Committee. They are parents of handicapped children and have indicated a desire to help you make your needs and opinions known to the schools. They can help you in getting information you need about situations involving your child that might not be available through the schools.

Dansville	Diane and Marvin Swan	623-6176
East Lansing	Mila Underhill	351-1246
Haslett	Pat and Myron Steffes	339-8911
Holt	Bea and John Gass	694-0721
Lansing	Susan and James Morlock	484-0857
Leslie	Martha and Otto Fancher	589-3022
Mason	Judy and Charles Lasater	676-4869
Okemos	Margaret and Harry Foster	349-3122
Stockbridge	Dolores and Elmer Schulte	851-8645
Waverly	Doreen and Arlie Kinnee	372-2207
Webberville	Charlotte and Joseph Cary	521-3371
Williamston	James and Gloria Hicok	655-1154
Ingham Appointment	Kendall Stonebrook	484-4772

Libraries

Human Ecology Library, Room 2, Human Ecology Bldg., MSU Phone: 355-7737

Books and journals in a variety of areas including child development, mainstreaming, curriculum assessment, etc. Materials can be used by anyone while in the library. MSU students and faculty may check materials out.

Ingham Intermediate School District Library, 2630 W. Howell Road, Mason, MI 48854 Phone: 676-1051

Books and journals on handicapping conditions, parent training, mainstreaming, assessment, curriculum. Also children's books and toys, and assessment tools. These materials can be used by anyone while in the library. Parents of handicapped children, public school teachers, support personnel, and administrators may check materials out.

PATHWAYS Project Library, Institute for Family and Child Study, Home Management House #2, Room 2, MSU, East Lansing, MI 48824 Phone: 355-7747

Books and articles on handicapping conditions, assessment, curriculum, parenting, child development, and mainstreaming. Also children's books. Available for any interested person to check out.

Family Growth Center library - Council for Prevention of Child Abuse and Neglect, Sandra Murphy, Central United Methodist Church, Capitol Ave. at Ottawa, Lansing, MI 48933 Phone: 485-9477

Open to public. Contains references about issues concerning parenting.

National Organizations for the Handicapped

Under "Parent Groups and Associations" are listed the local chapters of these organizations. The national organizations are listed here as they will provide, upon request, excellent free materials on particular disabilities understandable to the layman.

Autism: National Society for Austic Children, 169 Tampa Ave., Albany, NY 12208

Blind: American Council for the Blind, 1211 Connecticut Ave., NW, Washington, D.C. 20006

Cerebral Palsy: United Cerebral Palsy Assoc., 66 East 34th St., New York, NY 10016

Deaf: National Association of the Deaf, 814 Thayer Ave., Silver Spring, MA 20910

Deaf-Blind: National Association for the Deaf-Blind, 2703 Forest Oak Circle, Norman, OK 73071

Emotionally Disturbed: Mental Health Association, National Headquarters, 1800 North Kent Street, Arlington, VA 22209

Epilepsy: Epilepsy Foundation of America, 1828 L. Street, NW, Suite 405, Washington, D.C. 20036

Learning Disabilities: National Association for Children with Learning Disabilities, 4156 Library Rd., Pittsburgh, PA 15234

Mental Retardation: National Association for Down's Syndrome, P.O.Box 63, Oak Park, IL 60303

Mental Retardation: National Association for Retarded Citizens, 2709 Avenue E. East, P.O.Box 6109, Arlington, TX 76011

Physically Handicapped: National Easter Seal Society for Crippled Children and Adults, 2023 W. Ogden Avenue, Chicago, IL 60612

Physically Handicapped: Spina Bifida Association of America, 343 S. Dearborn St., Room 319, Chicago, IL 60604

Parent Groups and Associations in the Greater Lansing Area

The following is a list of organizations that are set up specifically for the parents of children with handicaps. As most associations are formed by non-profit and volunteer groups, contact persons and telephone numbers change frequently. If you have difficulty contacting an association on this list, call the Ingham Intermediate School District for assistance.

Parents of Special Children: Doug and Nancy Greenwold, 1799 Foxcroft, East Lansing MI 48823 Phone: 351-1504; Katy and Ron Allen, 14525 Dunn Road, Haslett, MI Phone: 675-7567

A parent group for parents of preprimary and primary age handicapped children. (The children have diverse handicaps, but all have had some experience with mainstreaming.) The goals of the group are to 1. educate themselves about resources, 2. provide support and encouragement for each other, and 3. work with the school system to provide good programming for the children.

Mental Retardation: Greater Lansing Association for Retarded Citizens, Enos Cook, President, 855 Grove Street, E. Lansing, MI 48823, Phone: 349-4084 or 351-9592.

A private association whose major function is ensuring that retarded persons of all ages and degrees of severity, in Ingham County, receive needed services such as counseling, education, recreation, day care, social activity, vocational training, sheltered work, financial assistance, publications, and referral assistance.

Mental Retardation: Multicap Parents Group, Bill and Kay Dowling, 7810 Blue Lagoon Dr., Lansing, MI 48917 Phone: 627-3350

A parent support and action group for parents of severely multiply impaired children.

Social and Emotional Impairments: Michigan Association for Emotionally Disturbed Children - Lansing Chapter, P.O.Box 1106, Lansing, MI Phone: (313) 873-3660

A private tri-county organization comprised of parents, professionals and any other members of the public who are interested in emotionally disturbed children. The association's purposes are promoting understanding of disturbed children by parents and the public through films, speakers, and tours of area facilities and the provision of referral services for parents.

Learning Disabilities: Greater Lansing Chapter of the Association for Children with Learning Disabilities, Mary Reich, President, 211 Lancer Lane, Lansing, MI

A parent organization for children with learning problems. The purpose is to promote better educational programs. They provide a means for parents to discuss problems, needs, and directions concerning their children.

Physical Handicaps: Capitol Area Spina Bifida Association, Mrs. Ruth Brazee, President, 1926 Mendota St., E. Lansing, MI 48823 Phone: 332-5754

A parent organization formed for providing support to the families of spina bifida children through sharing experiences and problem solutions.

Physical Handicaps: Multicap Parents Group, Bill and Kay Dowling, 7810 Blue Lagoon Lansing, MI 48917 Phone: 627-3350 See Mental Retardation listed above.

Physical Handicaps: United Cerebral Palsy Association of Lansing, Ruth Karslake, President, 933 Lantern Hill Dr., East Lansing, MI 48823 Phone: 332-6204

An organization of parents concerned with securing sources of help for cerebral palsy individuals.

Visual Impairments: Parents of the Preschool Visually Impaired, Mrs. Sherry Raynor, Home Phone: 349-9405 or Office Phone: 676-1051

An informal parent association which provides a means for parents of the young, visually impaired child to discuss problems and develop solutions concerning the educational and social adjustments of their children.

Hearing Impairments: Lansing Area Parents of the Hearing Impaired, Ronald W. Sinke, President, 3919 Hillborn Lane, Lansing, MI 48910, Phone: 882-8703

Provides a meeting place for parents of children with similar handicaps. Provides information to members on new developments and activities in the field of deaf and hard of hearing.

Hearing Impairments: Michigan Association for the Deaf-Blind, Michael Linden, President, Contact the Project Assistant for Services to Deaf-Blind Children at 373-3730 or 373-2987.

A charitable, non-profit organization to provide support and promote services for deaf-blind individuals and their families and to assist families in locating needed resources in the community and throughout the state.

Health Impairments: Child Health Clinic, George Dellaportas, M.D., Executive Director, Ingham County Health Department, 808 Southland, 1314 Ballard, Lansing, MI Phone: 393-5960

Preventive health care consisting of physical examinations, nursing consultation, immunizations and referral for services not provided by the clinic.

Health Impairments: Cystic Fibrosis Research Foundation - Greater Lansing Chapter, F. Earnest Parks, Treasurer, 1923 Old Mill Road, East Lansing, MI Phone: 351-5927

A private foundation founded by parents of C.F. children for the purpose of sharing experiences and gaining information about sources of assistance. The Greater Lansing Chapter currently supports a local treatment center. Services provided are furnishing free inhalation and mist equipment, instruction in therapy techniques, clinic monthly.

Health Impairments: Hemophilia of Michigan - Lansing Chapter, Pat Mould, 2000 Green Road, Ann Arbor, MI 48105; Phone: (313) 633-0551.

Provides information and referral regarding medical and dental care for the hemophiliac, as well as counselling and support for families of children with hemophilia. Sponsors three week summer camp program for youngsters 7-14 who have hemophilia.

Health Impairments: The American Diabetes Association - Ingham County Parent Group, Mrs. Ronald Cooper, 3510 Oak Cliff, Lansing, MI 48917, Phone: 372-5697

This organization is unique in that it offers counseling by a group of parents who themselves have diabetic children. It also offers diabetes planning, consultation, information and referrals to hospitals and other health agencies.

Health Impairments: Michigan Heart Association - Mid-Michigan Parents Group, Mrs. Brenda Hupetgartner, President, Phone: 485-6075.

This is a club for parents with children who have heart defects. It offers support and information, referral services. Monthly meetings are held with speakers on associated topics. Monthly newsletter.

Parenting Programs

The agencies listed here offer positive solutions to problems of parents and children with classes and workshops aimed at developing self-confidence in parents of children of all ages. Listing taken from May 4, 1979 Lansing Star, Handbook for Parents.

Association for Shared Childbirth, Joy Mahler, 1514 W. Saginaw, Lansing, MI, Phone: 372-9816

Offers 7 to 9 classes per month in shared childbirth. Can bring spouse or friend. 7:30 p.m.

Capital Area Counseling Center, Barry Kaufman, Joe Burns, 701 N. Logan, Lansing, Phone: 371-2550

Open to all parents, offers 9-week classes with discussion and lectures. Sliding scale fee, $0-35, evenings.

Catholic Social Services, Doris Ostrander, 300 N. Washington, Lansing, Phone: 372-4020

Offers Parent Aide Program to teenage mothers including rap group and information agency. 25¢ per session.

Central Michigan Association for the Education of Young Children, Elaine Williams, 5582 Haslett Rd., Haslett, MI 48840 Phone: 339-2026

Professional day care organization that offers some meetings on parental concerns to parents of young children. Write for meeting times and topics.

Central Michigan Council of Cooperative Nurseries, Sue Barnhardt, 3800 Hogback Rd., Fowlerville, MI 48836, Phone: (517) 223-8219

All parents welcome, holds periodic conferences which include parenting topics. Fee charged.

Council for Adoptable Children, Nancy Brazee (489-0661), 281 Every Rd., Mason, MI, Phone: 676-4579

All parents welcome, meet second Thursday of month, 8 p.m., at Pilgrim Congregational Church, 125 S. Pennsylvania, Lansing. Offers monthly speakers on parenting. Free.

Council for the Prevention of Child Abuse and Neglect, Virginia Sterling, 111 S. Capitol (P.O.Box 20247), Lansing, Phone: 484-8444

Offers child development classes at LCC aimed at parents. Tuition charged.

Cristo Rey Community Center, Connie Marin, 1314 Ballard, Lansing, Phone: 482-1387.

Offers free weekly discussion group on parent-child communication. Child care provided.

Expectant Parent Organization, Lynda Victor, 2620 Montego Dr., Lansing, Phone: 393-8558

Expectant and single parents meet at Cristo Rey Community Center (above). Offers ten-week classes for expectant and single parents and Caesarean birth preparation and four-week refresher. Ten-week course $30, four-week refresher, $12, Caesarean preparation $6, single parent course, free.

Family and Child Services, 300 N. Washington, Lansing, 48933 Phone: 484-4455

Family and marriage counseling, 8:30 - 5 p.m. weekdays, evenings by appointment. Sliding scale fee, medical insurance accepted.

Family Growth Center, Sandra Murphy, 215 N. Capitol, Lansing, 48933, Phone: 371-4350

The center provides a drop-in child care facility families can use up to ten times a month. Parents Coffee Hour three times a week. Sponsers recreation and leisure activities. Free, serves parents of children 2 weeks-6. Times are Mon. - Fri., 8:30 - 11 a.m., Mon., Wed., Fri., 1-4p.m.

Focus Program/Tri-County Community Mental Health Board, Dr. Groves, 615 Jones, Grand Ledge, Phone: 627-5722

Serves parents of Lansing, Haslett and Grand Ledge school district children. Contact agency for eligibility information.

Given Resources of Women (GROW), Joey Latterman, c/o 4534 Ethel St., Okemos, MI Phone:349-3521

Classes for mothers who want to learn more about their children including mothers who are certified to teach. $6 for four sessions. Classes held at the Unitarian Universalist Church, 855 Grove, East Lansing, MI

Ingham County Cooperative Extension Service, Pat Adams, Jeanne Soderlund, 127 E. Maple, Mason, Phone: 676-5222

Classes offered on request. Resource material for leading or teaching groups available. Free monthly newsletter, Family Forum on parenting issues.

Jean Granger Prenatal Clinic, 403 W. Greenlawn, Lansing, Phone: 371-5360

For mothers in Granger Clinic Program

La Leche League, Joey Latterman, 4534 Ethel, Okemos, Phone: 349-3521

Offers women monthly class running four months. Topics include parenting skills. Emphasis on breastfeeding. $8 dues, no course fee.

Lansing School District Continuing Edu tion, 500 W. Lenawee, Lansing, Phone: 374-4380

Offers classes through Lansing Community College. Call for information. Tuition charged.

Office for Young Children, Ingham County Health Department, Ken Sperber, 403 W. Greenlawn, Lansing, Phone: 371-5360

Offers free Child Care Seminars. Will provide speakers on various topics including parenting and young children at no charge. Publishes free resource guides to day care, recreation, toy making, and other topics of interest to parents.

Parents Anonymous, Suite 200, 111 S. Capitol, P.O.Box 20247, Lansing, 48901, Phone: 484-8444

All parents welcome, oriented toward parents who wish to avoid damaging children emotionally and physically. Central United Methodist Church, 215 N. Capitol, Lansing, 48933.

Parent Effectiveness Training, Eleanor Morrison, 469 N. Hagadorn, East Lansing, Phone: 332-8693

Conducts eight three-hour workshops on communication skills with children. $50 for single parents, $75 for couples, sliding scale based on income offered.

Probate Court, 300 Ingham County Bldg., 303 W. Kalamazoo, Lansing, Phone: 485-1751

Offers free 15-week discussion group about problems in dealing with children to parents of kids involved in the court system.

Psychology and Psychiatry Associates, Dr. Shirley Frank, Dr. Rafael Frank, 1504 E. Grand River, East Lansing, Phone: 332-2557

Offers ten-week program of formal presentation and discussion of topics of interest to parents of pre-school and elementary school children. $10 per session per couple charged.

Women's Resource Center/LCC, 419 N. Capitol, Lansing, Phone: 373-9970

Offers SD220, Parent-Child Communication. Tuition Charged. Offers counseling for women and men on parenting concerns.

Young Parent Educaional Developments, Mrs. Farmer, 500 W. Lenawee, Lansing, Phone: 374-4380

Aimed at expecting teenage mothers, pre-and post-natal. Provides alternative education courses and courses in child development, family living, infant care. Transportation and breakfast and lunch provided as needed. Free to girls who have not graduated from high school. High school grads pay $30.

Preschool Programs in the Greater Lansing Area Who Have Worked With the PATHWAYS Project in Integrating Handicapped Children

Abbott Nursery, Inc., Mrs. Joesph Sheedy, Director, 800 Abbott Road, East Lansing, MI 48823, Phone: 332-3304 (Mrs. Schmid)

Children ages 3-5. Purpose is to provide an educational program (as opposed to a babysitting service). The program aims to foster the individual development of the child through his own activity and discovery. One-half day part week program (nursery).

Community Nursery, Ruth Richardson, Director, 1309 W. Washtenaw, Lansing, MI 48915, Phone: 489-0525

Serves children ages 2½-6. The only day care center sponsored by United Fund with a sliding fee schedule (full day program).

Eastminster Child Development Center, Karen Ritts, Director, 1315 Abbott Road, E. Lansing, MI 48823 Phone: 351-6177

Serves children ages 2½ - 7, ages 2½ - 8 in summer. Has a summer school-age program and an after kindergarten program, full or half day.

Meridian Community Preschool, Helen Shipley, President, 1427 Haslett Road, Haslett, 48840 Phone: 655-2875 (Rita Leeman)

Works with a triangle of parent, child, and teacher. Social, creative, physical and emotional development is stressed. Self-sufficiency and independence are encouraged in an informal atmosphere. A parent cooperative preschool with a part day, part week program, for 3 and 4-year-olds.

MSAU Day Care Center, Carol Austin, Acting Program Coordinator, 1730 Crescent Rd., East Lansing, MI 48823, Phone: 353-5154

The program is concerned with the total growth of a child: social; emotional; physical; intellectual. Works cooperatively with families to provide a program that is geared to the individual child as a part of the group. Serves primarily MSU student family population. Ages 1 month to 5 years, full or part day program.

MSU Laboratory Preschool, Donna Howe, Acting Program Coordinator, Institute for Family and Child Study, MSU, E. Lansing, MI 48824 Phone: 355-7747

The faculty and staff of the Lab Preschool are dedicated to providing an individualized, success-oriented program for each child. A discovery learning approach is used to encourage children to build on their present skills. Careful attention is given to each child's relationship with other children and adults; understanding of emotions; body awareness; continued development of communication skills and problem solving skills. Part day, part week nursery program for ages 2-4.

Spartan Co-op Nursery School, Donna Howe, Director, MSU, E. Lansing, 48824 Phone: 355-0336

Children and parents are very important people. Spartan's goal is that each child grow toward independence with a positive image of self and world. A parent cooperative preschool; part-day, part-week program, ages 2-4.

Sunshine House Child Development Center, Debbie Hubbell, Director, 4410 W. St. Joseph, Lansing, MI Phone: 323-9130

Part-day, part-week nursery school, ages 2½-5. Purpose is to provide an educational program (as opposed to a babysitting service). The program aims to foster the individual development of the child through his own activity and discovery.

Preschool Special Education Programs in the Ingham Intermediate School District

See the section of this packet entitled "Working with the School District"

Recreation Programs for Handicapped Children

Easter Seal Society for Crippled Children and Adults, Inc., of Mid Michigan, 2901 Wabash St., Lansing, MI Phone: 394-5700

Programs sponsored by Easter Seal for crippled children include: Infant and Toddler Swim Program run by a physiotherapist. There is no lower age limit for these classes - 3 months to 3 years is the usual age range. For more information about this program, call Dawn Welch at Sparrow Hospital Recreational Department, 487-9237.

Dawn also coordinates a camping program for the entire families of pre-school children with handicaps. These camps are run during weekends at quarterly intervals. For more information call Dawn Welch 487-9237.

A play program is offered for handicapped infants and toddlers at the Ingham Medical Center. Infants and toddlers are admitted to the program by doctor's prescription. For more information call Joanne Fitzgerald T.P.T. 374-2418.

Easter Seal also sponsors a summer camping experience for handicapped children with qualified counselors and a variety of indoor and outdoor activities.

Motor Performance Study at Michigan State University, Rm. 38, Women's Intramural Bldg., East Lansing, MI Phone: 353-3866 (also, Early Childhood Motor Program and Remedial Motor Clinic - same contact, slightly different focus)

There are openings available in the pre-school motor performance program. This program is designed to improve fundamental gross motor skills in young children such as running, hopping, skipping, throwing, catching. It also includes rhythmic activities and general body management activities which are taught with the use of such equipment as balance beams, climbers, trampolines, scooter boards. Activities which increase body awareness are also taught as are creative and dramatic activities through movement.

The City of Lansing Parks and Recreation,- City Hall, Phone: 487-1270

The City of Lansing offers a variety of programs at several locations. There are three city community centers:

Genesee Center	Gier Community Center	Kingsley Community Center
501 N. Butler	2400 Hall Street	1220 W. Kalamazoo
Lansing, MI	Lansing, MI	Lansing, MI
Phone: 487-1056	Phone: 487-1031	Phone: 487-1370
	or 487-1032	Or 487-1371

Programs through the centers include: Swimming and Tennis (summer), Volley Ball (fall and winter), Basketball, Safe-Hockey (winter), and Baseball (spring).

Specific Handicaps

MENTAL RETARDATION

Community Mental Health Programs for the Retarded, Anila Singh, Ph.D., Director, 606 W. Shiawassee, Lansing, MI Phone: 487-6500

Provides the following services for the adult mentally retarded over the age of twenty-five or individuals who have successfully completed an education program in Clinton, Ingham and Eaton Counties: (1) Social and vocational evaluation, (2) pre-vocational and vocational training, (3) socialization, (4) communications, (5) daily living skills, (6) work activitiy, (7) counseling and aftercare services, (8) respite care, and transportation.

Greater Lansing Association for Retarded Citizens, Enos Cook, President, 855 Grove Street, East Lansing, MI 48823, Phone: 349-4084 or 351-9592

A private association whose major function is ensuring that retarded persons of all ages and degrees of severity, in Ingham County, receive needed services such as counseling, education, recreation, day care, social activity, vocational training, sheltered work, financial assistance, publications, referral assistance.

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Moore Living Center, Page Phillips, Director, 1401-1409 Edgewood Blvd., Lansing.

A private, non-profit group living facility with 16 residents in each home, offering family style supervised living and in-house programming for 32 mildly and moderately retarded adults 18 years or older. Residents are competitively employed or attend a sheltered workshop or day activity program.

Multicap Parents Group, Bill and Kay Dowling, 7810 Blue Lagoon Dr., Lansing, MI 48917 Phone: 627-3350

A parent support and action group for parents of severely multiply impaired children.

LEARNING DISABILITIES

Greater Lansing Chaper of the Association for Children with Learning Disabilities, Mary Reich, President, 211 Lancer Lane, Lansing, MI 48906 Phone: 485-0195

A parent organization for children with learning problems. The purpose is to promote better educational programs. They provide a means for parents to discuss problems, needs and directions concerning their children.

PHYSICAL HANDICAPS OF AN ORTHOPEDIC NATURE

Capitol Area Spina Bifida Association, Mrs. Ruth Brazee, President, 1926 Mendota Street, East Lansing, MI 48823 Phone: 332-5754

A parent organization formed for providing support to the families of spina bifida children through sharing experiences and problem solutions.

Cerebral Palsy Clinic, Patricia Bainbridge, Director, Audiology and Speech Science Building, M.S.U., East Lansing, MI 48824 Phone: 485-1051

The cerebral palsy clinic at MSU offers a parents education and assistance program for infants and their parents. Infants, children and adults are eligible for speech and/or language diagnosis, and speech and language therapy.

Easter Seal Society of Ingham County, Jack D. Oliver, Director, 2901 Wabash Rd., Lansing, MI 48933 Phone: 882-0211

Information, referral and follow-up services. Cost-free loan of orthopedic equipment. Some campership. Homebound outreach program. Year-round recreational services. Purchase of appliances and prescribed therapy. Provision of transportation services for mobility limited people.

Michigan Department of Public Health, Division of Services to Crippled Children, John W. Thomson, M.D., Director, Dept. of Public Health, Bureau of Maternal and Child Health, Lansing Regional Office, 3423 N. Logan St., Lansing, 48906 Phone: 373-3640

The program provides for medical care and treatment for eligible children who have handicaps or potential handicapping conditions. Services include hospitalization, medical care, and many ancillary services.

MSU Motor Performance Study, Rm. 38 Women's Intramural Bldg., East Lansing, MI Phone: 353-3866

The program is designed to improve fundamental gross motor skills in young children using rhythmic and general body management activities. Body awareness is increased through creative and dramatic activities.

MSU Office of Programs for Handicapped Students, Judy Kay Taylor, Coordinator, W409 Library, MSU, East Lansing, MI 48824 Phone: 353-9642

Goal: "Create a university environment conducive to full participation of handicapped students." Direct services are transportation to and from classes, removal of architectural barriers, counseling, referral, orientation for blind and other, reader service for the blind, transcription and typing services (class-related), deaf and hearing impaired, other class-related needs, counsel and advise university faculty and officials related to awareness of, and services to, handicapped student population. Consultation with non-university community, rehabilitation and parent groups, etc.

Multiple Sclerosis Society, Central Michigan Chapter, Gertrude Blay, Director, 1436 Wellington, Lansing, MI Phone: 372-4757

Serving Eaton, Clinton, Ingham, Livingston, and Shiawassee Counties, the Central Michigan Chapter acts as a liaison between patients and various health organizations. Services include public education through films and literature; diagnosis and evaluation (when approved in advance by the Chapter); equipment loans; and a friendly visitor program.

Muscular Dystrophy Association - Lansing Chapter, Mr. William Courtwright, Director 6425 S. Pennsylvania Ave., Lansing, MI Phone: 394-0050

An organization of interested persons offering services to victims of muscular dystrophy and related muscular diseases, including "Als." Local area includes Ingham, Eaton, Clinton and Livingston Counties. All services are free including wheelchairs, beds, clinics, summer camps and professional counseling.

United Cerebral Palsy Association of Lansing, Mrs. Jackie Garno, President, 142 Bessemaur Street, East Lansing, MI 48823 Phone: 332-3780

Organization of parents concerned with securing sources of help for cerebral palsy individuals.

VISUAL IMPAIRMENTS

Division of Services for the Blind, Harold Payne, Director, 300 S. Capitol, Lansing, MI 48926 Phone: 373-2062

The Division of Services for the Blind is part of the Department of Social Services and provides services for those who are legally blind (20/200 or less in the better eye with correction) and between the ages of 16 and 65. Services are provided through each County Department of Social Services. For further information on eligibility and services, call the Divison.

Leader Dogs for the Blind, Harold Pocklington, Director, 1039 Rochester Rd., Rochester, MI 48063 Phone: (313) 651-9011

A private, non-profit organization founded for the training and supplying of leader dogs to blind persons. The organization maintains a residential facility for short term training of leader dog recipients in the proper use of the dogs. Both dogs and training services are provided free of charge to young adults residing in the USA.

Michigan School for the Blind, Nancy J. Bryant, Superintendent, 715 West Willow Street, Lansing, MI 48906 Phone: 373-3730

Provides both academic and vocational education opportunities for visually impaired and/or visually impaired multiply handicapped Michigan children for whom special provisions are unavailable in local communities. Children of Michigan

residents from 5 through 25 years of age who meet the state definition of partial sight, legal blindness, or a combination of deafness and blindness are eligible.

Michigan State Library, Blind and Physically Handicapped Section, Susan Haskin, Director, 735 East Michigan Ave., Lansing, MI 48913 Phone: 373-1590

This library supplies reading material in the form of braille, large print, and recorded on disc and cassette, to anyone who cannot read normal printed material. Also loans record and cassette players.

Parents of the Preschool Visually Impaired, Mrs. Francis Wagner, President, 600 Shepard St., Lansing, MI Phone: 372-6646; or contact Mrs. Sherry Raynor, home phone: 349-9405 or office phone: 676-1051

An informal parent association which provides a means for parents of the young visually impaired child to discuss problems and develop solutions concerning the educational and social adjustments of their children.

HEARING AND SPEECH IMPAIRMENTS

Lansing Area Parents of the Hearing Impaired, Ronald W. Sinke, President, 3919 Hillborn Lane, Lansing, MI 48910 Phone: 882-8703

Provides a meeting place for parents of children with a similar handicap. Provides information to members on new developments and activities in the field of deaf and hard of hearing.

Michigan Association for Better Hearing and Speech, Dennis Ortiz, Director, 724 Abbott, East Lansing, MI 48823 Phone: 337-1646

Provides programs for prevention of deafness, conservation of hearing and speech habilitation and rehabilitation of the communicatively handicapped including the deaf. Audiology, speech pathology and services for the deaf programs are emphasized to serve people of all ages who have specific problems caused by or associated with loss of hearing and/or speech anomalies and in all ways possible, promote their general welfare. The provision of diagnostic, therapeutic, counseling, and rehabilitative services is directed toward the resolution of the communication disorders and/or various attendant medical, educational, social, vocational, and psychological involvements caused by the disorders.

Michigan School for the Deaf, Robert R. Gates, Superintendent, West Court St., and Miller Road, Flint, MI 48502 Phone: (313) 238-4621

The Michigan School for the Deaf is a part of the Michigan Department of Education's continuum of services to children with special needs. It serves deaf children from age four through completion of program. Referrals to the school are made via the appropriate intermediate school district.

Michigan State University Audiology and Speech Clinic, Leo Deal, Director, 101 Wilson Road, MSU, East Lansing, MI 48824 Phone: 353-8780

The clinic provides services for those who have speech, language, and/or hearing problems by providing evaluation and therapeutic services in these areas. The clinic also provides ear-nose-throat and social work services. Special programs in preschool speech and language programs are available in the areas of cerebral palsy and hearing impairment.

MULTIPLE IMPAIRMENTS

Michigan Association for the Deaf-Blind, Michael Linden, President, Contact the Project Assistant for Services to Deaf-Blind Children at 373-3730 or 373-2987.

A charitable, non-profit organization to provide support and promote services for deaf-blind individuals and their families and to assist families in locating needed resources in the community and throughout the state.

Multicap Parents Group, Bill and Kay Dowling, 7810 Blue Lagoon Dr., Lansing, MI 48917 Phone: 627-3350

A parent support and action group for parents of severely multiply impaired children.

HEALTH IMPAIRMENTS

Arthritis Foundation - Michigan Chapter, P.O. Box 831, Lansing, MI Phone: 485-4520
Contact Person - Mary Flugstad, Education Coordinator

Services provided: public information, monthly clinic, professional materials, instructional materials, consultant services, physical examination, medical treatment.

Child Health Clinic, George Dellaportas, M.D., Executive Director, Ingham County Health Department, 808 Southland, 1314 Ballard, Lansing, MI Phone: 493-5960

Preventive health care consisting of physical examinations, nursing consultation, immunizations and referral for services not provided by the clinic.

Children's Leukemia Foundation of Michigan, Sylvia Brown, Director, 17801 W. Seven Mile Rd., Detroit, MI 48235 Phone: (313) 534-5943

To promote research in leukemia and all serious blood diseases in children and adults. Provides blood bank and equipment program, including wheelchairs, braces and crutches, a limited hospital program, medication aid counseling service for stricken families and a speaker's bureau.

Cystic Fibrosis Research Foundation - Greater Lansing Chapter, Betty Kost, Clinic Assistant, 3741 Lochmoor Dr., Lansing, MI 48910 Phone: 882-9063

A private foundation founded by parents of C.F. children for the purpose of sharing experiences and gaining information about sources of assistance. The Greater Lansing Chapter currently supports a local treatment center. Services provided are furnishing free inhalation and mist equipment, instruction in therapy techniques, clinic monthly (primarily children).

Emphysema/Bronchitis Clinic, Ronald L. Cline, Director, Ingham Medical Hospital, 401 W. Greenlawn, Lansing, MI Phone: 371-2121 ext. 327

Complete evaluation, diagnosis, treatment and follow-up of any patients suffering from chronic obstructive pulmonary disease.

Greater Lansing Epilepsy Association, Paul T. Kay, President, P.O.Box 2301, Lansing, MI 48911 Phone: 484-3870 evenings

Offers comprehensive diagnostic evaluations, counseling, emergency assistance, education, public information and referral services.

Hemophilia of Michigan, Marvin Williams, Director, 2000 Green Road, Ann Arbor, MI 48105 Phone: (313) 663-0551

Provides information and referral regarding medical and dental care for the hemophiliac, individual and family counseling, diagnostic and evaluation clinics. Sponsors three week summer camp program for youngsters ages 7-14 who have hemophilia. Provides scholarships for education and training of eligible members. Sponsors professional education and training programs and distributes information on hemophilia to professionals and general public. Publishes newsletter, The Artery.

Kidney Foundation of Michigan, David St. Clair, Director, 3378 Washtenaw Ave., Ann Arbor, MI 48104 Phone: (313) 971-2800

Provides free information and counseling to Michigan patients and families afflicted with kidney disease. Referral services and free drug banks.

Lansing Dietetic Association, Jean Friend, President. The dieticians at Provincial or Ingham Medical Hospitals will assist or refer individuals to someone near them. Phone: 485-3271 or 626-6143

Dietary counseling for therapeutic diets and other nutritional needs.

The American Diabetes Association - Michigan Affiliates Inc., Hubert H. Baker, Director, 6131 W. Outer Drive, Detroit, MI 48235 Phone: (313) 342-9333

The American Diabetes Association - Michigan Affiliate, Inc., offers diabetes planning, consultation, information and referrals to hospitals and other health agencies; speakers, educational programs, literature, and counseling to diabetics and health professionals; year-round diabetes detection screening; funding for research; and an active youth program including a specially, medically supervised summer camp for children with diabetes. ADA-Michigan is coordinated through 31 local volunteer units.

Michigan Heart Association, Tri-County Heart Unit, Robert Dillaber, Director, 200 Mill Street, Lansing, MI 48933 Phone: 487-6084

A private association; it is affiliated with the American Heart Association and a member of the United Way of Michigan. In Michigan there are six regional offices under a central state office. Through regional offices a program of education on prevention and alleviation is conducted for parents and citizens. Programs suitable for any group ranging from literature suitable for teaching units to parent information are available. Direct information and referral service is maintained. Unit offers public and professional education services on heart attack, heart disease and stroke, offers films, speakers, and literature, and teaches emergency medical techniques (CPR). Also offers club for parents having children with heart defects and a recreation club of stroke patients and family members. Offers group counseling to heart attack patients and family members following hospital discharge.

GREATER KALAMAZOO AREA

Community/Social Services

Catholic Social Services of Kalamazoo, Inc., c/o Borgess Hospital, One East, Room 108, 1521 Gull Road, Kalamazoo 9:00-9:00 M-F

Individual and group counseling for adults, families and children for Catholics and non-Catholics. Fees: from $1.00 to $20.00 per session.

Comstock Community Center, 307 River St., P.O.Box 35, Comstock, MI 49041 Phone: 345-8556 8:30-5:00 daily

Services include: planned parenthood clinic, well baby clinic, public health nurse, family and children services caseworker.

Council for the Prevention of Child Abuse and Neglect (C/AN Council), Bev Kappelle, 345-6638 or Jan Dancer, 375-5291.

Coalition of community members working to prevent abuse/neglect and to improve community services and educational resources concerning child abuse.

Douglas Community Association, 231 E. Ransom St., Kalamazoo, MI 49007 Phone: 343-6185

Offers crisis intervention, services in mental health, employment, and community education.

Edison Center, Edison School, 924 Russell Ave., Kalamazoo, MI 49001 Phone: 342-4545

Outreach and contact into the neighborhood, crisis intervention and problem solving.

Kalamazoo County Department of Social Services, 666 Porter, Kalamazoo 49007 Phone: 385-1100, 8:00-5:00 M-F

Life Consultation Center, Hanson Building Third Floor, 230 North Burdick Mall, Kalamazoo, MI 49007 Phone: 381-9314

Case management services for developmentally disabled persons and their families.

Portage Human Concerns Council, 7211 Oakland Dr., Portage, MI 49081 Phone: 327-7832 or 327-2432

Provides social services, senior citizens, FISH program, therapy sessions for single parents.

Vicksburg Community Center, 116 S. Main St., Vicksburg Phone: 649-1120

Provides aid and social service to residents of Vicksburg, Fulton and Schoolcraft.

Cooperating Centers: PATHWAYS Project Outreach in Kalamazoo County

Canterbury Children's Center, Sally Householder, Director, 2210 Wilbur Street, Kalamazoo, MI 49007 Phone: 349-8907

Full and part time day care, 2-6-year-olds, year round.

Comstock Kid's Korner, Emma VonZehle, Director, 6330 King Highway (Comstock Community Center), Comstock, MI 49041 Phone: 345-7243

Full and part time day care 2½ - 6-year-olds, after kindergarten program, year-round transportation available.

Continuing Education for Young Women: Elanor Miller Memorial Infant Day Care Center, Dorothy Lassen, Director, 715 South Westnedge, Kalamazoo, MI 49007 Phone: 385-0522

Full and part time day care, 6 weeks-6-year-olds, school year, transportation.

Judson Day Care Center, Angie Waschowsky, Director, 4409 Grand Prairie, Kalamazoo, 49007, Phone: 343-4871

Full and part time day care, 2½-12-year-olds, after kindergarten and after school programs year round.

Sara Swickard Preschool, Chris Limbocker, Director, 1211 Knollwood, Kalamazoo, Phone: 383-4092

Full and part time day care, 2½-12-year-olds, after kindergarten and after school programs (primarily serves WMU student families) year round.

Schoolcraft Community Nursery School, Liz Avink, Membership chairperson, Presbyterian Church, Schoolcraft, MI 49087 Phone: 679-4605 (106 S. Grand, Box 417, Schoolcraft)

Parent Cooperative nursery school, 3 and 4-year-olds, school year.

Westwood Parents Cooperative Nursery School, Marie Fredericks, Teacher, 538 Nichols Road, Kalamazoo, MI 49007 Phone: 343-0110

Nursery school: ½ day sessions, 3, 4, 5-year-olds, school year.

Other Potential Programs for Integrating Young Handicapped Children in Kalamazoo County

Bread and Roses, Susan Kaiser, and Chris Payton-Travers, Directors, 508 Denner, Kalamazoo, MI 49007, Phone: 349-1754

Full and part time day care, 2½ - 6-year-olds, year round.

Children's Center, Susan Walz, Director, 5196 Comstock Avenue, Comstock, MI 49041 Phone: 381-3785

Full and part time day care, 2½-6-year-olds, year round.

Child Development Center, (in process of hiring new director), 1401 Cherry Street, Kalamazoo, MI 49001 Phone: 383-4076

Full and part time day care, 2-6-year-olds, year round.

Discovery Center, Karen Phillips, Director, 4120 W. Michigan, Kalamazoo, MI 49007, Phone: 349-1869

Nursery school: ½ day sessions, 2½-5-year-olds, school year.

Guilford Preschool Nursery, Pat Guilford, Director, 9735 Portage Road, Portage, MI 49081, Phone: 327-3581

Nursery school: ½ day sessions, 3, 4, 5-year-olds, school year.

Parent Cooperative Nursery School, Mary Smith, Teacher, 1515 Helen Avenue, Portage, MI 49081, Phone: 344-8833

Nursery school: ½ day sessions, 3, 4, 5,-year-olds, school year.

Play 'N Learn, Esther Wang, Director, 504 S. Westnedge, Kalamazoo, MI 49007, Phone: 382-2369

Nursery school: morning sessions only, 3, 4, 5-year-olds, school year.

Richland Preschool Learning Center, Barbara Morgan, Director, 6274 North 32nd St., Richland, MI 49083 Phone: 629-4438

Nursery school: ½ day sessions, 3, 4, 5-year-olds, school year.

Counseling Services

Child Guidance Clinic, 2615 Stadium Dr., Kalamazoo, 49008 Phone: 343-1651, 8:00-5:00 M-F, 6:00-9:00 p.m., Tuesdays

Diagnostic and consultation services for emotional and mental disorders for children in school or under 18 years if out of school.

Delano Clinic, 1521 Gull Road, Kalamazoo, 49001 Phone: 383-7340

To provide mental health care for persons with problems unrelated to drugs or alcohol.

Family and Children's Services, 1608 Lake St., Kalamazoo 49001, 8:00-9:00 Mon. and Thurs., 8:00-5:00 Tues., Wed., Fri.

Private agency offering social services to families, counseling, foster homes. Respite Care - Co-op respite care.

Kalamazoo Consultation Center, 225 Dewing Building, 132 N. Burdick Mall, Kalamazoo, 49006, Phone: 343-6109, 343-6100, 8:00-7:00 Mon., 8:00-5:00 Tues.-Fri.

Crisis counseling and mental health services. Operation turn around.

Kalamazoo County Community Mental Health Services Board, 610 S. Burdick, Kalamazoo, MI 49001 Phone: 345-8501 8:00-5:00 M-F

Planning and administration for mental health services to any group feeling they provide such services and wishing to request funds.

Kalamazoo State Hospital - Children's Services, Box A, Kalamazoo 49001 Phone: 345-7194 8:00-5:00 M-F

Psychiatric therapy for emotionally disturbed children 8-16 who are not mentally retarded.

Occupational Health Center, 4425 W. Main, Kalamazoo 49007 Phone: 382-6402 8:30 - 5:30 M-F

24 hour crisis intervention. Outpatient psychiatric clinic for working people.

Pet Project: Preprimary Evaluation and Training - KVISD, 4606 Croyden Ave., Kalamazoo, Phone: 381-4620 ext. 281

Diagnostic evaluation services for preschool-aged children suspected of having handicapping conditions. Serving children aged 0-5, services are free. Parent/child training program (INTRAC) for parents of preschool-aged handicapped children.

Planned Parenthood Association of Kalamazoo County, Inc., 612 Douglas, Kalamazoo, Phone: 349-8631

Comprehensive family planning information and services to all residents of Kalamazoo County. Consumer Advisory Board.

Southwest Michigan Council of Cooperative Nursery Schools, Irene Atkinson, President, Phone: 327-8682

Association of area parent cooperative nursery schools. Provides information and referrals on cooperative nursery schools and sponsers a yearly conference of workshops and speakers.

Educational Programs

American Red Cross Handicapped Swim Program, 516 W. South, Kalamazoo, 49006 Phone: 343-1618

Swimming for handicapped children.

Cheff Center for the Handicapped, Augusta, MI located on No. 43rd St., off M-89 between Richland and Battle Creek Phone: 731-4471 8:00-4:00 M-F

Horseback therapy to handicapped persons. No fee.

Continuing Education Program for Pregnant Adolescents and Eleanor Miller Memorial Infant Day Care Service, 600 W. Vine St., Community Education Center, Kalamazoo 49008 Phone: 349-1194 ext. 209 M-F September to June

Education, health care and social services for pregnant adolescents. Day care for infants while mothers are in school.

Day Care and Nursery Schools - Kalamazoo County Community Coordinated Child Care (4-C) Association, 2210 Wilbur St., Kalamazoo, MI 49008 Phone: 349-8907

Child care association providing information and referral to local child care programs, training to child care providers and coordination of activities to enhance services to young children and their families.

Kalamazoo Valley Intermediate School District - Special Education Division, 1819 E. Milham Rd., Kalamazoo 49002 Phone: 381-4620

Special education services for handicapped age 0-25.

Kennedy (John F.) Center, 1411 Oakland Dr., Kalamazoo 49008 Phone: 381-2266 9:00-3:30 M-F

School for mentally handicapped children. No fees.

Lakeside Boys and Girls Residence, 3921 Oakland Dr., Kalamazoo 49001
Phone: 381-4760 8:00-5:00 M-F

To give care and treatment to emotionally disturbed children in an open setting.

Pet Project: Preprimary Evaluation and Training - KVISD, 4606 Croyden Ave., Kalamazoo Phone: 381-4620 ext. 281

Diagnostic evaluation services for preschool-aged children suspected of having handicapping conditions. Serving children aged 0-5, services are free. Parent/child training program (INTRAC) for parents of preschool-aged handicapped children.

Southwest Michigan Council of Cooperative Nursery Schools, Irene Atkins, President
Phone: 327-8682

Association of area parent cooperative nursery schools. Provides information and referral on cooperative nursery schools and sponsors a yearly conference of workshops and speakers.

Handicapper Advocacy/Parent Groups

Association for Prepared Childbirth, 1601 Lane Blvd., Kalamazoo 49001 Phone: 381-1499

Classes in the Lamaze method of prepared childbirth. Fees: $4.00 membership, $18.00 6-week course fee.

Greater Kalamazoo Epilepsy Association, P.O.Box 2381, Kalamazoo 49003, Phone: 381-1486

The association promotes public understanding of epilepsy.

Kalamazoo Association for Retarded Citizens, P.O.Box 349, Kalamazoo 49005 Phone: 349-2621 9:00-3:00 M-F

Fosters and promotes public understanding, education and acceptance of the mentally retarded and the development of programs in their behalf.

Kalamazoo County Chapter - Muscular Dystrophy Association of America, Inc., 2216 Amherst, Kalamazoo 49008 Phone: 342-5288

Offers clinic fees, flu shots, orthopedic devices, camp, diagnostic tests.

Kalamazoo Federation of the Blind, P.O.Box 603, Kalamazoo, 49006 Phone:344-6643

Kalamazoo Parents of Down's Syndrome Children, 1604 Spanish Rd., Kalamazoo, Phone: 381-0626

Group of mothers involved in raising Down's Syndrome children.

Kalamazoo Society for Crippled Children and Adults, Inc., 301 W. Cedar St., Kalamazoo 49006 Phone: 345-6532 8:00-12:00 and 1:00-5:00 M-F

Promotes welfare of crippled children through education and treatment. No fees.

Kalamazoo Shrine Club - Crippled Children Project, 1104 Fletcher Ave., Kalamazoo, 49007 Phone: 342-4869

Provides assistance of all kinds to crippled children under 16.

Michigan Association for the Deaf, Ardyce Germain, President, 8377 W. Long Lake, Kalamazoo, MI 49007 Phone: 323-0771

Michigan Association for Emotionally Disturbed Children (MAEDC)--Kalamazoo Area Chapter, Jackie Metheany, 10528 Portage Road, Portage, MI Phone: 327-5523

Michigan Association for Children with Learning Disabilities, 442 Parkdale Blvd., Parchment 49004 Phone: 345-5347 or 345-8756

Information and parent counseling. Membership dues $5/year.

National Association of the Physically Handicapped, Inc.- Paper City Chapter, 626 Lynn, Apt. 107, Kalamazoo 49008 Phone: 342-1878

Goal is to improve the welfare of physically handicapped over 18 years. Fees are $4.00/year.

Spina Bifida Association of Michigan - Southwestern Chapter, 12127 East G. Avenue, Augusta, MI 49012

Sponsers many activities and services (Spina Bifida Family Camp, Myclomening-ocele Clinic, Newsletter, annual symposium) for children/individuals with Spina Bifida and their families.

Kalamazoo Valley Intermediate School District

DIRECTORS AND SUPERINTENDENTS IN SPECIAL EDUCATION

Kalamazoo Valley Intermediate School District Assistant Superintendent for Special Education: Mrs. Ann Lee Decent, KVISD, 1819 East Milham Road, Kalamazoo, MI 49002, Phone: 381-4620 ext. 236

Director of Special Education, Eastern Service Area: Mr. John Engle, Comstock Public Schools, Adult Education Center, Comstock, MI 49041 Phone: 385-2008

Director of Special Education, Southern Service Area: Mr. Larry Coin, Portage Public Schools, 8111 South Westnedge, Portage, MI 49081 Phone: 827-3081

Director of Special Education, Kalamazoo Township: Dr. Tim Crowner, Kalamazoo Public Schools, 1220 Howard, Kalamazoo, MI 49007 Phone: 385-0591

SPECIAL EDUCATION PARENT ADVISORY COMMITTEE

These individuals have been selected by their local school district administration and appointed to the Parent Advisory Committee. They are parents of handicapped children and have indicated a desire to help you make your needs and opinions known to the schools. They can help you in getting information you need about situations involving your child that might not be available through the schools. The representative's district, name, child's handicap, and phone number are listed.

Kalamazoo: Mr. Wilson Bassett, Learning Disabled, 381-2962
Schoolcraft: Mrs. Laurie Blodgett, Learning Disabled, 679-5591
Portage: Mrs. Mary Cooper, Hearing Impaired, 327-8485
Portage: Mr. Hugh Flickinger, Learning Disabled, 327-6515
Climax-Scotts: Mr. Fred Gridley, Learning Disabled, 746-4418
Portage: Dr. James Jacobs, Emotionally Impaired, 349-4823

Kalamazoo: Mrs. Noreen Jolliffe, Severely Multiply Impaired, 381-0626
Climax-Scotts: Mrs. Roger Knowles, Learning Disabled, 746-4484
Gull Lake: Mrs. Sally Lindsay, Educable Mentally Impaired, 629-9238
Comstock: Mrs. Karen Longanecker, Severely Multiply Impaired, 385-2615
Galesburg-Augusta: Mrs. Norma Shilts, Emotionally Impaired, 665-7183
Schoolcraft: Mr. Dale Southworth, Physically Impaired, 679-4056
Parchment: Mrs. Dora Sulka, Learning Disabled, 349-7545
Parchment: Mrs. Nancy Topp, Severely Mentally Impaired, 349-9101
Kalamazoo: Mrs. JoAnn Tree, Physically Impaired, 345-2053
Comstock: Mrs. Sharon Westafer, Learning Disabled, 349-2971
Gull Lake: Mrs. Sally Warner, Severely Mentally Impaired, 629-4081

Medical/Therapeutic Services

Borgess Hospital, 1521 Gull Road, Kalamazoo 49001 Phone: 383-7000

Pediatrics Clinic 8:30-5:00 M-F, Phone: 383-7305, Mental Health Center, Sickle Cell Anemia Clinic, Phone: 383-4846, Free testing and counseling for sickle cell anemia. No fee. Genetic counseling, etc.

Bronson Methodist Hospital, 252 E. Lovell St., Kalamazoo 49006 Phone: 383-7654

Social Service Department, Room 118 Harding Building Phone:: 383-6300

Constance Brown Hearing and Speech Center, Borgess Hospital, 1521 Gull Rd., Kalamazoo 49001 Phone: 343-2601 8:00-5:00 M-F

Speech and hearing evaluation and therapy.

Family Health Center, Inc., 117 W. Paterson, Kalamazoo 49006 Phone: 349-2641

Comprehensive health services, provides transportation. For any "low-income" resident of Kalamazoo County. Fees based on ability to pay.

Kalamazoo County Health Department, 418 W. Kalamazoo Ave., Kalamazoo 49006 Phone: 383-8888 8:00-5:00 M-F

Kalamazoo County National Cystic Fibrosis Foundation, 726 Lane Blvd., Kalamazoo 49001 Phone:345-2619

Inhalation equipment free of charge, drug bank.

Kalamazoo Visiting Nurse Association, 610 S. Burdick, Kalamazoo Phone: 343-1609 8:00-4:30 M-F

Nursing care in the home. Basic fee $7.00 or on ability to pay.

Michigan Department of Public Health - Services to Crippled Children, Kalamazoo County Health Dept., 418 W. Kalamazoo Ave., Kalamazoo 49006 Phone: 383-8738 Representative Mrs. Remola Ellis available Mon., Tues., Fri.

Medical care and treatment for crippled children under 21.

Office of Service for the Blind, Michigan Department of Social Services, 519 S. Park, Kalamazoo 49007 Phone: 345-2113 8:00-5:00 M-F

Provides services to blind in rehabilitation and orientation. Library.

Poison Control Centers:

Borgess Hospital, 1521 Gull Rd., Kalamazoo Phone: 383-4815 24 hour service
Bronson Methodist Hospital, 252 E. Lovell, Kalamazoo Phone: 383-6386 24 hours
University of Michigan, Ann Arbor, Phone: (313) 764-5102
Provide technical data and information on poisons. Emergency treatment.

Southwest Region, Michigan Tuberculosis and Respiratory Disease Association, Lawyer's Building, Suite A, 232 W. Michigan, Kalamazoo 49006 Phone: 381-8212 8:00-5:00 M-F

Educational and informational services.

Western Michigan University - Department of Blind Rehabilitation, 3513 Sangren Hall, WMU, Kalamazoo 49001 Phone: 383-8020 8:00-5:00 M-F

Rehabilitation teaching and orientation and mobility to blind persons. Low-vision clinic.

Western Michigan University Occupational Therapy Clinic, East Campus, Occupational Therapy Dept., WMU, Kalamazoo 49001 Phone: 383-1765

Provides occupational therapy.

Western Michigan University - Speech, Hearing and Language Clinic, Department of Speech, Pathology and Audiology, Speech and Hearing Center, East Campus, WMU Kalamazoo 49001 Phone: 383-0963

Clinical help to speech or hearing handicapped children and adults. No fees.

Western Michigan University - Multiclinic, Western Michigan University, Kalamazoo 49001 Phone: 383-0963 8:00-5:00 M-F

To provide diagnostic services for selected multiply-handicapped children and adults.

GLOSSARY

by Mary R. Wandschneider
and Nancy A. Carlson

GLOSSARY*

by Mary R. Wandschneider and Nancy A. Carlson

The following terms are frequently used in reference to handicapping conditions and services to handicapped children.

-A-

ABDUCTION - Movement of a limb outward away from the body.

ACHIEVEMENT TESTS - A standardized test that measures what a child has already learned: Usually given in public schools.

ACTIVE MOVEMENTS - Movements a child does without help.

ACTIVITIES OF DAILY LIVING (ADL) - feeding, dressing and other activities necessary for functioning in a family, in school and in the community.

ACUITY - Sharpness or accuracy.

ACUITY, AUDITORY - The ability to receive and differentiate auditory stimuli.

ACUITY, VISUAL - The ability to see and to differentiate meaningfully and accurately objects in one's field of vision.

ADAPTIVE BEHAVIOR - The achievement and maintenance of an ongoing relationship between the individual and his/her environment. This relationship is supportive of the individual's survival and development.

ADDUCTION - Movement of a limb toward the center of the body.

AFFECTIVE - Pertains to feelings or emotions.

AMNIOCENTESIS - The withdrawal from the pregnant mother's womb of some amniotic fluid (usually between the 14th and 18th weeks of pregnancy) in order to chemically analyze cells from the baby. It is used to try to prevent handicaps by treating Rh problems and by allowing abortions of those fetuses which are discovered to be abnormal. It can also help parents who are afraid to take a chance that their baby might be born with some defect that is in their families.

ANXIETY - Tension or uneasiness that stems from the anticipation of danger, the source of which is largely unknown or unrecognized.

APHASIA - A weakening or loss of the ability to send and/or receive verbal and/or written messages, not connected with diseases of the vocal cords, eyes or ears.

APTITUDE TEST - A test which measures someone's capacity, capability or talent for learning something.

ASSOCIATED REACTIONS - Increase of stiffness in spastic arm and leg muscles resulting from effort elsewhere in body.

ASTIGMATISM - The blurring of vision due to an uneven curvature of the front of the eye. It is a refractive error.

ASYMMETRICAL - One side of the body different from the other - unequal.

ATACTIC - No balance - jerky.

ATAXIA - Condition in which central nervous system deficits lead to uncoordinated muscle movement.

ATHETOID - Child with uncontrolled movement of limbs and/or head and continuous unnecessary movements.

ATTENTION FIXATION (Overattention) - The child will focus on one object and seem unable to break the focus.

ATTENTION SPAN - The extent to which a person can concentrate his attention on things.

* Adapted from: Mauldin, Janeen A. "Special Education in Michigan: A Handbook for Parents," (a pamphlet), Lansing, MI.: Michigan Department of Education, 1975.

-A- (cont.)

AUDIOGRAM - A graph showing the range of hearing. Hearing sensitivity for air and bone conducted sounds shown on the graph.

AUDIOLOGIST - A person who identifies and measures hearing loss and helps in the rehabilitation of those with hearing impairments.

AUDIOLOGY - The study of hearing and hearing disorders.

AUDIOMETER - An electronic device for measuring hearing ability (or lack of it).

AUDITORY - Pertaining to hearing.

AUDITORY ATTENTION - The ability to concentrate on information received through listening.

AUDITORY BLENDING (Synthesis) The ability to combine sounds into syllables, syllables into words, words into sentences or stories.

AUDITORY COMPREHENSION - To understand what one hears.

AUDITORY CONSTANCY - To recognize sound families such as rhyming units (boat and coat).

AUDITORY DISCRIMINATION - The ability to detect subtle differences among sounds in words (tap-cap; cap-cop).

AUDITORY FIGURE-GROUND DISCRIMINATION- The ability to concentrate on what one should listen to and to ignore what is unimportant (following conversation in a noisy atmosphere).

AUDITORY MEMORY - To remember what is heard (words, numbers, stories). This includes both short and long term memory.

AUDITORY PERCEPTION - The ability to receive sounds accurately and to understand what they mean.

AUDITORY SEQUENCING - The ability to remember the order of items given orally (January, Feb. March).

AURAL REHABILITATION - Rehabilitation of a person with a hearing handicap.

AUTISM - A severe disorder with nearly complete inability to communicate in social interaction. The child lives in a self-stimulated, self-isolated world.

AUTOMATIC MOVEMENTS - Movements done without thought or effort.

-B-

BALANCE AND RHYTHM - The ability to maintain gross and fine motor balance and to move rhythmically.

BEHAVIOR MODIFICATION - A procedure that is based on the belief that all behavior is learned and therefore can be unlearned (changed). One must decide the specific behavior to be changed and decide on a definite plan for accomplishing that goal.

BINOCULAR DIFFICULTIES - A visual impairment due to the inability of the two eyes to function together.

BODY IMAGE - An awareness of one's own body and the relationship of the body parts to each other and to the outside world.

BODY LOCALIZATION - The ability to locate parts of one's body.

BRAIN DAMAGE - Any structural or chemical defect of the brain. This damage could occur before, during or anytime after birth.

BRAIN-INJURED CHILD - A child who before, during or after birth has received an injury to or suffered an infection of the brain. As a result of this, there are disturbances which prevent or hinder the normal learning process.

-B- (cont.)

BRAIN SCAN - This procedure is similar to an X-ray. A fluid is injected into a vein. The fluid takes about 30 minutes to reach the brain. Then pictures are taken which allow the doctor(s) to see if there are any diseased tissues such as tumors, etc., present. The fluid leaves the body in six hours.

-C-

CENTRAL NERVOUS SYSTEM (CNS) - It is made up of the brain and spinal cord.

CEREBRAL DOMINANCE - The control of activities by the brain, with one hemisphere or side of the brain used more than the other. In most people the left side of the brain controls the language function and the left side is thought to be the dominant hemisphere. The right side controls nonverbal and creative functions. It may be dominant in a percentage of the population.

CEREBRAL PALSY (CP) - A general term used to describe several conditions resulting from injury to the brain; usually before or immediately after birth. It varies widely in degree of severity and body parts affected. There are three major types:

1. Spastic - Constant tense and tight muscles
2. Athetoid - Characterized by constant succession of involuntary movement
3. Ataxia - Loss of muscular coordination.

CHILD FIND PROGRAMS - Interagency activities associated with the early identification of handicapped infants and young children for the purpose of intervention with appropriate medical and educational treatment.

CHRONIC - A disease of slow progress and long duration.

CHRONOLOGICAL AGE - The actual age of a person.

CLINICAL TEACHING (Prescriptive Teaching) The goal is to prescribe individual learning experiences to meet the unique needs of a particular child.

CLOSURE - Ability to recognize an object when one or more parts are missing. Ability to recognize a word or sentence when one or more sounds are missing.

COGNITIVE - The act or process of knowing and understanding. Analytical or logical thinking.

CONCEPT - An abstract idea.

CONCEPTUAL DISORDER - Inability to formulate an abstract idea.

CONCRETE - Naming a thing as opposed to naming a quality. MAN is a concrete term but HUMAN is abstract.

CONDUCTIVE HEARING LOSS - Reduction or total elimination of sound transmission through external and middle ear processes to inner ear.

CONGENITAL - Condition existing from birth.

CONSTANCY, PERCEPTION OF - Ability to see sameness of essential form despite changes of image on retina (for example- recognizing a table whether you're standing above it, below it or across from it.)

CONVULSIVE DISORDER - The term is sometimes used interchangeably with seizure disorder and epilepsy. Generally, it includes grand mal, petit mal, psychomotor and Jacksonian seizures. There are many other types of epilepsies.

COORDINATION, VISUAL MOTOR - The ability to relate vision with movements of the body or parts of the body.

COORDINATION, GROSS MOTOR - Pertains to use of large muscle groups (jumping, running).

-C- (cont.)

COORDINATION, FINE MOTOR - Pertains to usage of small muscle groups (writing, cutting).

CYSTIC FIBROSIS - Metabolic disorder. The body's glands produce an excess of mucous, saliva, and sweat which clog the lungs and organs. Resistence to respiratory disease is low.

-D-

DECODING - Ability to change sounds or symbols into ideas.

DELAYED SPEECH DEVELOPMENT - This is a broad term which refers only to the fact that a child has not acquired speech either at the expected time or with the expected accuracy.

DEPARTMENT OF PUBLIC HEALTH (D.P.H.) - The state level department which administers statewide health programs.

DEVELOPMENTAL - Successive changes during the process of natural growth.

DEVELOPMENTAL IMBALANCE - An uneven development and differences in abilities among various mental and physical factors.

DEVELOPMENTAL READING - The pattern and sequence of normal reading growth and development in a child in the learning-to-read process.

DIPLEGIA - Paralysis affecting like parts on both sides of the body.

DIRECTIONALITY - Awareness of the two sides of the body and the ability to identify them as left and right and to project this correctly into the outside world, as in knowing which is the right hand of a person facing you.

DISCRIMINATION - The process of detecting differences.

DISSOCIATION - Inability to see the "wholeness" of objects. Tendancy to see small segments without relation to the total picture of which they are a part.

DISTRACTIBILITY - Tendency for one's attention to be easily drawn to outside stimuli or to focus on minor details with a lack of attention to major aspects.

DOMINANCE - Established knowledge to the preferred side of the body.

DOWN'S SYNDROME - A condition associated with chromosomal abnormality. Characteristics: small skull, slightly flattened, short, flat-bridged nose; shortened fingers; upward slant of the eyes; moderate to severe mental impairment (in the past referred to as Mongoloid children).

DYSCALCULIA - Difficulty or inability to learn good handwriting habits or the inability to perform the motor movements needed for handwriting, usually due to brain malfunction.

DYSLEXIA - Difficulty or inability to learn to read due to brain malfunction. A disorder where children, despite conventional classroom experience, fail to attain the skill of reading.

-E-

ECHOLALIA - Constantly repeating what others say. (At nine to ten months of age, a baby may be heard imitating sounds which OTHERS have made.) At 4-5 years of age it becomes parrot-like.

EDUCABLE MENTALLY IMPAIRED (EMI) - A term to describe the mildest form of retardation. The child may appear normal until school starts. May learn to read and do other academic work. With proper training, may be expected to work and live independently.

-E- (cont.)

EDUCATIONAL PLANNING AND PLACEMENT COMMITTEE (E.P.P.C.) - A committee, including the parents and others working with the handicapped child, which decides whether the child is eligible for special education. It also determines in which programs the child will participate.

ELECTROENCEPHALOGRAM (E.E.G.) - The brain cells give off very small amounts of electricity known as brain waves. A painless test taken by a machine called the electroencephalograph which records the brain waves. This helps Drs. to determine which cells are injured and capable of overactivity.

EMOTIONALLY IMPAIRED (E.I.) - Characterized by behavior patterns of withdrawal, explosiveness, hyperactivity, or acting out in society. Also called emotionally disturbed.

ENCEPHALITIS - Inflamation of the brain.

ENCODING - Changing ideas to words or written symbols.

ENCOPRESIS - Lack of bowel control not due to illness or organic defect.

ENDOCRINOLOGIST - A doctor that deals with the science of the endocrine glands, especially in their relation to bodily changes.

ENDOGENOUS - A condition or defect based on hereditary or genetic factors.

ENURESIS - Involuntary emission of urine.

EPILEPSY - A neurological disorder characterized by sudden recurrent seizures. (See seizures)

ETIOLOGY - The cause or origin of a condition.

EVALUATION, MEDICAL - Examination and diagnosis by a physician.

EVALUATION, PSYCHOLOGICAL - An assessment to determine the level of functioning through the use of group and/or individual tests. The tests determine the level of function in three areas:

1. Cognitive - How much one knows.
2. Affective - Pertains to feelings or emotions.
3. Perceptual Motor - Control, coordination and appropriate responses from all parts of the body.

Recommendations for treatment or placement when indicated, are made as a result of the evaluation.

EXOGENOUS - A condition or defect resulting from other than heredity or genetic factors (such as environment or injury).

EXPRESSIVE LANGUAGE SKILLS - Skills required to produce language for communication with other people. Speaking and writing are expressive language skills.

EYE-MOTOR COORDINATION - The ability to relate vision with movements of the body or parts of the body.

-F-

FIGURE-GROUND DISTORTION - This occurs when a person cannot focus on an object because the background appears to interfere.

FIGURE-GROUND PERCEPTION - Ability to distinguish an object from the background.

FINE-MOTOR COORDINATION - Development and control of small muscles such as those used to cut, hold a pencil, etc.

FLEXION - Bending of a body joint -- elbows, hips, knees, etc.

-F- (cont.)

FRUSTRATION LEVEL OF READING - The level at which the material is too difficult for the individual to master. Comprehension score of less than 50%.

FUNCTIONALLY RETARDED - One who functions as if mentally retarded, but is not. This may be caused by emotional disturbance, malnutrition or cultural deprivation.

-G-

GENE - The unit in the chromosome that controls the development of characteristics that are passed from parents to offspring. - Example - color of eyes.

GRAND MAL - Seizure. Typically, the loss of consciousness, all muscles tightening, usually some jerky movements of legs and arms, the eyes may roll up. Also frothing at the mouth, wet or soiling themselves, can bite tongue or cheek.

GROSS MOTOR - The development and awareness of large muscle activity. Coordination of large muscles in a purposful manner such as walking and jumping.

1. Bilateral - Ability to move both sides of the body at the same time (jumping).

2. Unilateral - Ability to move one side of the body without moving the other (hopping).

3. Cross Lateral (Cross-Pattern)- Ability to move different parts of the opposite sides of the body together or in different sequences (skipping). It is a highly integrated movement.

-H-

HABILITATION - The act of preparing for a useful life through education, training or treatment.

HAPTIC COMMUNICATION - by means of non-verbal signals generated by direct contact (shaking hands).

HARD-OF-HEARING (Hearing Impaired) - Those in whom the sense of hearing, although defective, is somewhat functional with or without a hearing aid.

HEAD CONTROL - Ability to control position of head.

HEARING AID - An instrument to make sounds louder. There are four basic types. Helpful for <u>conduc - tive</u> hearing losses.

HEARING IMPAIRED - A diagnosis based upon an evaluation by an audiologist and otolaryngologist, and other pertinent information. The hearing impairment may interfere with learning.

HEARING LOSS, CONDUCTIVE - Due to a problem affecting the outer or middle ear. The main problem is lack of acuity: when signals are loud enough, they can be received and acted upon.

HEARING LOSS, SENSORINEURAL - Permanent loss due to damage to either the cochlea, auditory nerve, or both. A few of the problems include lack of acuity and poor understanding or discrimination of speech and other signals.

HEMIPLEGIA - Paralysis of one side of the body.

HEMOPHILIA - Failure of the blood to clot normally. A sex-linked disease, it is present in males and carried in females.

HEREDITY - Passing genetically from one parent to offspring.

HIGH RISK - Children with suspected potential learning problems.

HYDROCEPHALUS - The accumulation of cerebrospinal fluid within the ventricles of the brain. This fluid causes brain pressure, deterioration and enlargement of the head.

HYPERKINETIC - HYPERKINESIS - HYPERACTIVE- Person with abnormally increased activity levels and lacking the ability to control it. The child may be constantly in motion, always into things and difficult to restrain. Either the syndrome or adult perception of problem, decrease with age.

HYPEROPIA - Farsightedness. Vision for distant objects is good but it is difficult for the farsighted person to get near objects into clear focus. This affects reading.

HYPERTONIC - Increased muscle tension.

HYPOGLYCEMIA - The deficiency of sugar in the blood.

HYPOKINESIS - The absence of a normal amount of bodily movement and motor activity. Extreme lack of movement or listlessness.

HYPOTONIC - Greatly decreased muscular tone or tension (floppy).

-I-

IMPULSIVE - Acting without thinking in an uninhibited way.

INATTENTION - Inability to focus on any particular activity for any length of time.

INDIVIDUAL EDUCATIONAL PLAN (I.E.P.) - A statement of the yearly instructional plan for children receiving special education programs and/or services. It must include: a statement of the child's present level of educational performance; a statement of annual goals and short term instructional objectives; a statement of the specific special education and related services to be provided to the child, and the extent to which the child will be able to participate in regular education programs; the projected date for initiation of services and the anticipated duration of services; appropriate objective criteria and evaluation procedures and schedules.

INDEPENDENT READING LEVEL - Level where extensive reading can be done successfully.

INHIBITION - Control of muscle tightness and influences of reflexes (or tendencies).

INNER LANGUAGE - Language of inner thought.

INSTRUCTIONAL READING LEVEL - Level at which systematic instruction may be started.

INTELLIGENCE QUOTIENT (IQ) - A ratio indicating how one's mental ability compares with others of the same age. It can also be expressed in terms of a mental age for children under the age of 16.

INTELLIGENCE TEST - A standardized test which gives a statistic presumably indicating one's mental ability. The tests provide an overall estimate of general intelligence.

INTERMEDIATE SCHOOL DISTRIC (I.S.D.) - Serves local school districts by providing services and personnel that would be too costly for one local district to pay for by itself, and it assists local districts as they try to work together for large scale programming. It acts as an avenue of communication between the Michigan Department of Education and the local school district.

INVERSION - Turned upside down.

INVOLUNTARY MOVEMENTS - Unintended movements.

-K-

KINETIC COMMUNICATION - Communication by means of signals generated by movement and received through vision (shrug of the shoulders).

-K- (cont.)

KINESTHESIA - The sense by which one feels his own muscle movement.

-L-

LABILE - Unpredictable behavior, rapid shifts of mood and emotional expression.

LANGUAGE - An organized system of symbols (words) used by people to communicate on an abstract level.

LANGUAGE, EXPRESSIVE - Speaking, signing, writing. "Communicating idea to another."

LANGUAGE, RECEPTIVE - Listening and reading. Understanding what others communicate to you.

LANGUAGE-EXPERIENCE APPROACH TO READING - A method of teaching reading based on the experiences of the children. Materials are dictated by the child, written down by the teacher, then used in class as the material for teaching reading.

LATERAL CONFUSION (mixed Laterality) - Tendency to perform some acts with a right side preference and others with a left, or the shifting from right to left for some activities; may result in delayed motor skills, letter reversals.

LATERALITY - Awareness of the two sides of one's body and the ability to identify them as left or right correctly.

LEAST RESTRICTIVE ENVIRONMENT (L.R.E.) - A provision of the federal "Education for All Handicapped Children Act of 1975," requiring that to the maximum extent appropriate, handicapped children are educated with children who are not handicapped in a regular classroom. The L.R.E. is a continuum of services from the most restrictive of an institution or hospital to the least restrictive of instruction in a regular classroom. Any program along the continuum may be appropriate for a particular child; and therefore, the L.R.E. for him/her.

LINGUISTICS - The scientific study of the patterns of language systems, the nature of language, its development, its function, and the way it is manipulated.

LOCOMOTION - Movement from one place to another (walking, rolling, etc.)

-M-

MACROCEPHALY - Excessive size of head.

MATURATION - Process of coming to full development.

MATURATIONAL LAG - Slowness in certain specialized aspects of neurological development. There is no structural defect, deficiency or loss.

MEMORY, SHORT TERM - to remember what has been presented within the preceding few seconds.

MEMORY SPAN - Number of items that can be recalled immediately after presentation.

MENTAL AGE - Age level of mental ability, partially determined by standardized intelligence tests.

MICHIGAN DEPARTMENT OF EDUCATION (M.D.E.) The state level department which oversees statewide programs.

MICROCEPHALY - Abnormal smallness of the head with limited or no room for growth. (The soft spots have closed.)

MINIMAL BRAIN DYSFUNCTION (M.B.D.) - Neurological deficit or suspected nerve damage within the brain. Usually results in a form of learning disability.

MISARTICULATION - Inability to say words clearly. Example: saying wed for red. (Developmentally appropriate under age four.)

MODALITY - A way of acquiring sensation; visual (sight), auditory (hearing), tactile (touch), kinesthetic (sensation), olfactory (smell), and gustatory (taste) are the common sense modalities.

MORPHEME - The smallest unit of meaning in a language. The word boy is one morpheme.

MOTIVATION - Desire to accomplish something or reach a goal.

MOTOR - Pertaining to use of muscles.

MUSCULAR DYSTROPHY - A group of several genetic disorders which all involve progressive damage and weakness to the muscles supporting the skeleton.

MYOPIA - Nearsightedness. Vision is good for close objects. It is a refractive error.

-N-

NEONATAL - Refers to that period immediately following birth and through the first month of life.

NEUROLOGICAL EXAMINATION - Tests to determine disease of or damage to the nervous system.

NEUROLOGIST - A doctor who specializes in the diseases of the nerves or nervous system.

NEUROLOGY - The science dealing with the diseases affecting the nerves and the nervous system.

-O-

OCCUPATIONAL THERAPIST (O.T.) - Person trained to provide O.T. as described below.

OCCUPATIONAL THERAPY (O.T.) - Treatment provided by a therapist trained in helping the patient develop mental as well as physical well being in all areas of daily life, e.g., self-care, prevocational skills, etc. The therapist participates in the treatment process to help speed up the recovery and rehabilitation process.

OCULAR - Pertaining to the eye.

OCULAR PURSUIT - Ability to follow a moving object with the eye.

OLFACTORY - Pertaining to the sense of smell.

OPERATIONS - Processes involved in thinking.

1. Cognition - Comprehension or understanding, knowing.
2. Memory - Retention and recall of information.
3. Convergent Thinking - Bringing together of known facts.
4. Divergent Thinking - Use of knowledge in new ways. Creative thinking.
5. Evaluation - Critical thinking.

OPTHALMOLOGIST - A medical doctor who treats disease of the eye. They also prescribe glasses.

OPTICIAN - A person who makes or sells glasses in accordance with prescriptions of an eye doctor.

OPTOMETRIST - A person trained in the practice of testing the eyes for defects of vision, in order to fit them with glasses.

ORGANIC BRAIN DAMAGE - Specific set of symptoms which indicate physical damage to the brain.

OTOLARYNGOLOGIST - A doctor who specializes in ears, nose & throat.

-P-

PATHOLOGY - The scientific study of the nature of disease.

PEDIATRICIAN - A doctor who specializes in the care of children.

PERCEPTION - The process of interpreting sensory information. The accurate mental association of present stimuli with memories of past experience.

PERINATAL - Occurring just before or after birth.

PERSEVERATION - Continuing to behave or respond in a certain way when it is no longer appropriate. Difficulty in shifting from one task to another.

PETIT MAL - A form of epilepsy which, to the onlooker, has the appearance of day-dreaming or staring into space for a few moments - sometimes the eyes blink. Slight jerking of the legs or arms may occur.

PHONEME - Smallest unit of sound in any language.

PHONETICS - Study of all the speech sounds in language and how these sounds are produced.

PHONICS - Use of phonetics in the teaching of reading. Relating the sound (phoneme) of the language with the equivalent written symbol.

PHONOLOGY - System of speech sounds in a language.

PHYSICAL THERAPIST - Person trained to provide P.T. as described below.

PHYSICAL THERAPY - Treatment of disorders of bones, joints, muscles and nerves. With the prescription of a physician, the therapist applies treatment to the patient in the form of heat, light, massage, exercise, gait training, etc.

PHYSICALLY AND OTHERWISE HEALTH IMPAIRED (P.O.H.I.) - A diagnosis based upon an evaluation by an orthopedic surgeon, internist, neurologist, pediatrician or equivalent and other pertinent information. The E.P.P.C. may determine the person has a physical or other health impairment which interferes with learning or requires physical adaptation in the school environment.

POSITION IN SPACE, PERCEPTION OF - The accurate interpretation of an object as being behind, before, above, below or to the side, knowing where your body is in relation to other things.

POSTNATAL - Occurring after birth.

PRENATAL - Occurring before birth.

PROGNOSIS - Forecast of the probable course of a disease.

PROGRAMMED READING - Method of teaching reading that uses organized self-instruction and self-correcting materials.

PRONE - Lying on stomach.

PSYCHIATRIST - A medical doctor who specializes in the diagnosis and treatment of emotional disorders and diseases of the central nervous system, which affect individual behavior and personality adjustment.

PSYCHOLINGUISTICS - A field of study that combines two disciplines - psychology and linguistics - to examine the total picture of the language process.

PSYCHOMOTOR - Muscle responses (see Fine and Gross Motor).

PSYCHOTHERAPY - A type of treatment of personality problems that is based primarily upon verbal or nonverbal communication with the patient as distinguished from other therapies that use behavior modification, drugs, group interaction, etc.

READING COMPREHENSION - The ability to understand what one has read.

RECEPTIVE LANGUAGE - receiving and understanding spoken, written or signal communication. The receptive language skills are listening and reading.

REFLEX - An involuntary or automatic response. The eyes automatically blink to reflex action if a moving object approaches within an inch or two of them.

REHABILITATION - A procedure to restore a person to a condition of good health, useful, or constructive activity.

REMEDIAL READING - Specialized instruction in reading aimed at increasing speech and improving comprehension by correcting poor reading habits.

RESPITE CARE - short term relief for parents from care of their child in their own home or caregiver's home.

-S-

SCHOOL PSYCHOLOGIST - A person trained to give psychological tests, interpret results and suggest appropriate educational approaches to learning or behavioral problems.

SEIZURE - Sudden attack occurring when a group of brain cells become overactive causing disharmony in the brain. This may remain in one area or spread to other areas of the brain. After the seizure has ended harmony is restored among the brain cells.

a. Petit mal - mild form of epileptic attack - child appears to be daydreaming.

b. Grand mal - a more involved epileptic attack with or without coma.

c. Psychomotor - rhythmically repeated movements and some loss of consciousness are the manifestations of this type of seizure.

SELF-CONCEPT - A person's idea of himself.

SENSORY MOTOR INTEGRATION - Coordination of fine and gross motor activities: coordination between information about what your body is doing and the information it is receiving from its senses.

SENSORY DEPRIVATION - Occurs when a person cannot use (for whatever reason) one or more of the five senses (hearing, seeing, smelling, tasting, touching) or cannot receive through one or more of the senses. If not stimulated in early infancy use of a sense(s) may become underdeveloped.

SEQUENCE - Events having an order in time. Example: throw the ball and THEN pick up the jacks.

SEQUENCE, LEFT to RIGHT - A sequence every child must learn in order to read.

SEQUENTIAL (SERIAL) MEMORY - Remembering things in order (days of the week), counting, order of words in sentences).

SEVERELY MENTALLY IMPAIRED (S.M.I.) - An educational term used to describe the most severe form of educational retardation. May learn activities of daily living to a limited degree. Will always need to be in a supervised learning situation.

SEVERELY MULTIPLY IMPAIRED (S.X.I.) - A diagnosis based upon previous medical records, any educational history, evaluation by a neurologist, orthopedic surgeon, opthalmologist, audiologist, or equivalent, and other pertinent information. All the following behavioral characteristics apply:

a. Severe multiplicity of handicaps in the physical and cognitive domains.

b. Inability or expected inability to function within other special education programs which deal with a single handicap.

c. Development at less than the expected rate of age group in the cognitive, affective or psychomotor domains.

SHELTERED WORKSHOP - A facility licensed by the State and Federal Department of Labor to employ handicapped persons at less than the minimum wage. Sheltered workshops may use actual work to provide job training or evaluate handicapped persons' interests and abilities.

SHUNT - A "tube with a valve" surgically inserted for the purpose of regulating or diverting the flow of spinal fluid or block in the body. Prevents excessive fluid from surrounding the brain as in hydrocephalus.

SIBLING - A brother or sister.

SIBLING RIVALRY - Competition between children in a family; normally expected to a degree.

SNELIAN CHART - A poster with different size letters used to test visual acuity at 20 feet. A 20/20 score means that the child sees at 20 feet what the normal eye sees at 20 feet. Therefore, normal vision.

SOCIAL ACCEPTANCE - The ability to get along with one's peers (friends).

SOCIAL HISTORY - The story of the child and his family, facts & feelings.

SOCIAL MATURITY - The ability to assume personal and social responsibility, expected of persons of similar age.

SOCIAL PERCEPTION - Ability to interpret the social environment and relate to it in an appropriate way.

SOCIAL WORK - Professional field that helps people adjust to their environment or social situations.

SOFT NEUROLOGICAL SIGNS - Symptoms that indicate there may be some damage to the brain and/or nervous system.

SPATIAL RELATIONSHIPS, PERCEPTION OF - Knowing the positions of two or more objects in relation to one's self and in relation to each other.

SPATIAL ORIENTATION (position in space) - The accurate interpretation of an object as being behind, before, above, below, or to the side.

SPECIAL EDUCATION - Programs or services designed to meet the individual needs of children who deviate from the "normal" or "average" either physically, mentally, socially or emotionally, and who need different methods, materials or techniques in order to develop their maximum potential.

SPEECH - A learned process referring to the oral expression of language.

SPEECH PATHOLOGIST OR SPEECH THERAPIST OR TEACHERS OF SPEECH AND LANGUAGE IMPAIRED - Persons trained to provide analysis, diagnosis, and therapy for speech and language disturbances.

SPINA BIFIDA - A congenital defect in the spinal column caused by lack of fusion of the vertebrae.

STANDARDIZED TESTS - Measurement instruments for which norms of performance have been developed and tested for their reliability and ability to measure accurately.

SYMBOL - Something that represents or stands for something else. Information in the abstract form.

SYMBOLIZATION - Process in which spoken or written or signed symbols take on meaning, that is, are understood by the individual and in turn are used for a verbal or written expression.

SYNDROME - Set of symptoms which occur together.

SYNTAX - The grammar system of a language. (The way sentences are composed.)

-T-

TACHISTOSCOPE - Machine that shows written material for a short period of time. Used to improve speed and span of visual perception of words.

TACTILE - Sense of touch.

TACTILE DEFENSIVENESS - a condition children experience which causes them to not like to be touched (especially lightly) nor to touch some types of textures. Extent can vary from day to day.

TACTILE DISCRIMINATION - Ability to identify and match objects by touching and feeling.

TASK ANALYSIS - Technique of examining a particular task to discover each individual part of it and the processes needed to perform it in appropriate order.

TEACHER-CONSULTANT - A teacher who works with handicapped students who are in regular classroom programs. The T-C may work with the student, his teacher and/or the parent(s).

THERAPY - Any form of treatment that is designed to lead to improvement of a physical, mental, emotional or social program.

TIME ORIENTATION - Ability to judge lapses in time and to be aware of time concepts (day, month, year, time of day, seasons).

TONE - A sound with a specific pitch. Also used to describe the physical condition of muscles or other parts of the body.

TONIC NECK REFLEX - A primitive reflex that is normal in newborn infants where arm and leg movements are governed by head movements. When present in a child of seven or eight months of age or older it may be an indication of a neurological problem.

TRAUMA, BIRTH - Physical injury of a baby during its delivery. (Psychoanalysts believe birth itself is always traumatic.)

TRAUMA, PSYCHIC - An experience of a painful emotional character which has more or less lasting effects on the person, possibly affecting adjustment.

TRAINABLE MENTALLY IMPAIRED - A diagnosis based upon a comprehensive evaluation by a school psychologist, certified psychologist or certified consulting psychologist and other pertinent information. All the following behavioral characteristics apply:

a. Development at a rate approximately 3 to 4½ standard deviations below the mean as determined through intellectual assessment.

b. Lack of development primarily in the cognitive domain.

c. Unsatisfactory school performance not found to be based on social, economic or cultural background.

TREMOR - Involuntary movement or quivering.

TRUNK - Body (minus legs, arms & head).

-U-

UROLOGIST - A doctor who specializes in that branch of medicine which deals with the urinary tract (pertains to the containing or secreting of urine) in both men and women, and with the genital organs of men.

-V-

VISUAL ACUITY - Ability to see forms and letters clearly from a certain distance. This is an objective, precise measurement.

VISUAL ASSOCIATION - Ability to distinguish, compare or relate information received through sight.

VISUAL CLOSURE - Ability to recognize or identify an object, despite the fact that part of it is missing.

VISUAL COORDINATION AND PURSUIT - Ability to follow moving objects and symbols with coordinated eye movements.

VISUAL DISCRIMINATION - Using the eyes to discriminate letters and words and shapes (to see sameness and differentness).

VISUAL FIGURE-GROUND DISCRIMINATION - Ability to see objects in foreground and background and to separate them meaningfully.

VISUAL MEMORY - Ability to remember things that have been seen.

VISUAL-MOTOR COORDINATION - The ability to use the eyes to coordinate muscle movement, such as those required in eye-hand tasks.

VISUAL MOTOR MEMORY - Pupil can draw designs and symbols following brief visual exposure.

VISUAL PERCEPTION - The identification, organization, and interpretation of data received through the eye.

VISUAL SEQUENTIAL MEMORY - The ability to remember or visualize the letters and order of letters in words. Important for spelling.

VOLUNTARY MOVEMENTS - Movements done with intention and concentration.

WORD ATTACK SKILLS - The ability to analyze words.

WORK ACTIVITY CENTER - A program using paid employment as a therapeutic activity for handicapped persons whose impairments are so severe as to make their productive capacity severely limited.

WORK STUDY - Means on-the-job training, related counseling and follow-up services.

ARTICLES AND FORMS OF USE IN INTEGRATING YOUNG HANDICAPPED CHILDREN

compiled by Mary Wandschneider

Articles may be of interest to teachers, center directors, aides, volunteers, parents, and referring agency people.

Forms may be of particular use to programs integrating preschool handicapped children.

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Article 1

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INTEGRATING the SPECIAL CHILD

IDEAS FOR EARLY CHILDHOOD EDUCATORS

By Helene Ginsberg, Specialist
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Child Study
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For many years, various early childhood programs have accepted children with special needs and problems on an individualized basis. Now, as our society moves to integrate or mainstream handicapped individuals into all aspects of daily living, that practice is receiving public attention. In the preschool years, this practice is particularly meaningful. Young children generally are very accepting and do not attach a negative value to differences in others. Also, early childhood programs have a great deal to offer the young handicapped child: varied experiences, group contact with other young children, a structured and balanced day and many opportunities to play, learn and use all of the senses. Early childhood programs are also non-competitive--children are not tested or expected to learn specific academic tasks. Play and interaction are the major aspects of the curriculum. Also, teachers of young children are especially sensitive to the individual needs and differences of children. Groups of children are fairly small in most preschool programs and are well supervised by adults. This combination can enable "handicapped" and "typical" children to learn and play together to the benefit of all!

At Michigan State University, a federally funded program called the PATHWAYS Project has been working for the past 3 years to develop a model for integrating young handicapped children into existing regular early childhood settings. It has used the early childhood laboratories on campus--a nursery school, a parent cooperative nursery school and a day care center--and is housed within the Institute for Family and Child Study. We would like to share with you some of the elements that we have found contribute to the successful integration of young handicapped children.

Who are the Children?

Many young children experience various sensory, developmental, health and physical problems. When these characteristics seem to interfere with a child's growth they are labelled as handicapping conditions. Some children have difficulty seing--they may be partially sighted or totally blind. Other children have difficulty hearing--they may be hearing impaired or deaf. Some children develop more slowly than other children their own age--their development is delayed or "retarded." Some children have difficulty controlling their impulses or feelings -they may be very frightened, anxious, hostile or withdrawn. These are generally called emotional problems. Some children have problems with learning tasks, they may not understand basic concepts or they have difficulty coordinating the movements with their brains. These children have "learning disabilities." Other children have long-term health problems like epilipsy, heart conditions and other diseases which disrupt their lives. Some children have physical problems, such as cerebral palsy, which affects the nerves and muscles. Others are born without certain limbs. Some children use wheelchairs or are aided by braces or artificial limbs. Some children have difficulty with a specific process, such as speech and language. All of these different children are labelled as handicapped. However, it is important to realize that, though each may have unique characteristics, first and foremost all are children! They are more <u>like</u> other children than they are different.

Placement - A Key to Success

All children are unique and different, and all have very special needs. To meet the needs of a handicapped child participating in a regular early childhood setting, it is important to match the child with the classroom, the teacher and the group of children. Some children do well in small groups, others in larger groups. Some children need more structure, others need the opportunity to make many decisions for themselves. Some teachers are more accepting of one type of handicapping condition than another. Some children, though they are 5 years old, may do well with children who are 3 years old, or in a mixed group of 2½ - 5-year-olds. It is very important, when considering an early childhood program for a handicapped child, to look at all the possibilities, to understand the child's developmental needs and to match child and facility according to the child's needs and abilities. The cooperation of all persons involved with the child is helpful in getting a rounded picture of what kind of setting will be most appropriate for each child.

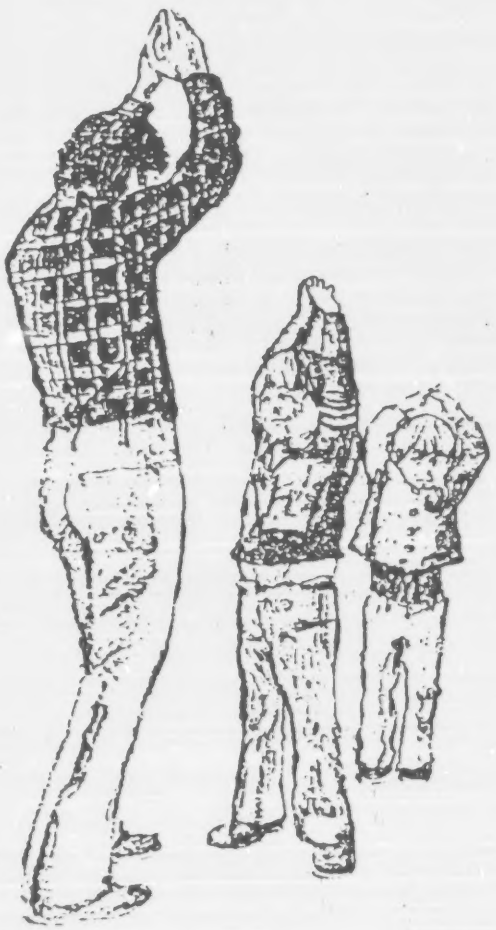
More Alike Than Different

All children have certain basic needs that must be met for them to grow and develop to their full potential. In that way, all children are very much alike. Children who experience handicaps have the same needs that other

children have. The child who wears leg braces or a hearing aid is still a child. And all children need to feel loved and appreciated by the adults around them. All children need to communicate with others and be spoken with to have things and experiences described and explained. All children need to be listened to respectfully by others. All children need to feel successful and capable. All children need to feel independent and self-sufficient in some basic ways. All children need to feel safe, both physically safe from harm and danger, and psychologically safe from ridicule, cruelty and disrespect. All children also need models of appropriate behavior. Children need opportunities to explore, discover and experience. Children need to play with other children and to use their senses and their bodies in free and unique ways. All children need to feel that they belong,that they are wanted by others, that there is a place for them within the group. Handicapped children not only have the same needs as other children, but they also have many of the same abilities. Handicapped children need the opportunity to be treated by others as children with abilities, instead of what they can't do. Keeping in mind that children who may appear different than others still have the same needs is an important way of getting to know the handicapped child and of overcoming any feelings of awkwardness or unfamiliarity.

What Can Teachers Do?

Learn as much as you can about the child: Get to know the child's way of coping, communicating, playing. Find out about the child's interests. Get acquainted with the child as a person. Home visits help enormously, because the child is usually most comfortable at home.



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. . . Nothing is so clear in this world as the glory in the special child. It shines in it's hard times with words---they are songs if you listen carefully. And in his troubled walk--- there is a dance if you pay attention..*

*from a poem by Ned O'Gorman, for the Joseph P. Kennedy Jr. Foundation publication LET'S PLAY-to-GROW, 1977 1701 K. Street N.W. Suite 205, Washington, D.C. 20006.

Learn as much as you can about the child's handicap: Get clear, direct explanations of the child's condition, and understand as much as you can about the characteristics of that condition. This will help you to explain to others, as well as to interpret the child's behavior, responses, etc. Learn about the special equipment a child may use, and how to help the child manage it. Your local library or school district has information about various handicapping conditions.

Use the child's parents as a resource: The handicapped child's parents are usually the experts about the child's behavior, needs and special interests. Look to them for assistance in getting to know what is characteristic of their child. Be certain to maintain contact with the parents, especially when things are going well, as well as when there are problems.

Model positive behaviors: Other children will look to you to model how to relate to the new child. Be positive and set a model for normal interactions. Treat the child as you would treat any other child. You will probably find that few special adjustments need to be made. Remember to set the same limits with the handicapped child as you would with others. If you don't, that child will stand out as different. Answer children's questions clearly and accurately. If they ask why Joey can't see, explain in a way that they will understand but be careful not to plant fears that it will happen to them. For many children it is appropriate to say "Sally isn't talking yet" instead of "Sally can't talk". Help other children to hear or see by masking those senses. Make experiences of individual differences and ways of seeing, moving, hearing and communicating a regular part of your curriculum.

Know the other resources involved with the child: Many handicapped children interact with a great number of educational, medical and therapuetic services. It helps to know what else is going on in a child's life--often that explains behavior that may seem unusual. Also, it is good for the other agencies to know that the child is attending your program. With parent's permission, inform the others involved that this child is in your class and invite them to visit. You may be able to exchange useful ideas and information.

Divide your attention equally in the classroom: Be sure that all children are getting enough attention. Do not focus exclusively on the handicapped child. On the other hand, don't ignore him or her. Be sure that all children feel they can get your attention through positive means.

Pay attention to transitions: Each child has his/her own way of changing from one activity to another or from one environment to another. Some children may need extra assistance

during the transitions from one major period of the day to the next. Some children need help going from noisy, active play to quiet periods like snack. Other children need a very long time to feel comfortable in a new environment and cannot be pushed into trusting the new class, teacher and children. A friendly, supportive and calm demeanor on your part will help the new child feel welcome and trusting. Each child is different.

Your best equipment is a good attitude:

In working with children who have special needs or unique characteristics, there is no substitute for a positive, accepting attitude. You will transmit that to everyone else in the room. Unfortunately, many of us grow up with stereotyped fears or inhibitions about people who act or look different. It helps to talk about those feelings and be sure you feel comfortable with those differences before you accept a child into your classroom.

Preparing the Environment

Integrating children who are different into an early childhood program is an exciting and challenging venture. Preparation in several ways is important to create a positive environment in which all the children can feel comfortable. Be sure to discuss your ideas with other teachers and parents in your program. They may have questions, concerns or fears that need to be addressed. Parents of typical children can play an important role in supporting the integration effort by talking with their children about their classmates and exploring feelings about being handicapped and by welcoming the parent of the handicapped child. It helps to arrange visits by the child and the parents before enrollment. That way, you can get a feel for the way the child will react to the group setting and other children can gradually become acquainted with the new child. You may also want to invite handicapped adults into your classroom to play and talk with your group. Encourage children to ask

questions and to learn about their different lifestyles. Including crutches and wheelchair props in the dramatic play corner is another way to support the integrated classroom.

Ask for Help!

Teachers need support to meet the challenge of integrating handicapped children. When you need help ask for it. Use the resources provided by the local school district, by the child's doctor(s), by the child's parents. Ask other teachers to share ideas or experiences. It helps to identify people who can assist you in problem solving when you hit a snag in your program. Serving the needs of all children in our early childhood programs requires cooperation. Sometimes you will have to take the first step to let others know that you need their help.

It is our hope that young children who learn to accept the individual differences and uniqueness of others will grow to become compassionate adults. Providing opportunites for young children with different needs and developmental abilities to play and learn together, benefits everyone. We have much to learn from others who adapt to life differently than the norm.

Article 2

WHY PRESCHOOL INTEGRATION?

1. Children learn about differences and people's abilities very early.
2. Preschools are without pressures of the public school, i.e., to achieve.
3. More difference in abilities is accepted on the preschool level, as these are the "catching up years."
4. The curriculum for preschool is often more open, with choices and with a variety of experiences.
5. Image-wise, children attending typical preschool have a better chance of being enrolled in integrated public school.
6. There are no grades or levels of accomplishment to meet in preschoool; no examinations to pass.
7. There is a great need for preschool placements for children labelled mentally retarded and/or developmentally delayed.

- Ellen Barnes
Center on Human Policy
Syracuse, New York
September, 1975.
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ARTICLE 3

THE CASE FOR "SPECIAL" CHILDREN

Eleanore Grater Lewis

"The child with special needs can be included in programs serving a cross-section of children to the mutual benefit of all."

The delay between the first diagnosis of a child's handicap and the institution of a regimen of treatment for the child is a time gap familiar to many of us. This is especially true of the emotionally disturbed child. Fortunately, public understanding and acceptance of exceptional children and their problems have increased in recent year; moreover, a wider variety of more sophisticated testing materials has emerged. Yet, unfortunately, the early identification and diagnosis of a child's problem does not always insure immediate or early treatment. The parent may adopt a "wait and see' attitude: "Will my child outgrow his problem?" An increase in the severity of the problem may cause the parent to place the child's name on one of the many long waiting lists. Indeed, many of these children are denied entry into preschool programs because of their particular handicaps. We strongly believe that the experience of a preschool program is vital for the successful assimilation of handicapped children into the "normal" world, and in many instances may prepare them for public school experience. For purposes of clarity and communication, we will henceforth refer to all children with some physical, mental or emotional problem as "special," and all others as "normal," recognizing, of course, the many problems associated with "normal" children.

At the Lexington Nursery and Kindergarten School for "normal" children aged three to seven, we feel that we have reached a partial solution for the "special" child. Since our school opened 14 years ago we have welcomed and encouraged "special" children to integrate our classes, where, in a relaxed atmosphere, they are exposed to other children and interested, creative teachers. Our experience in helping "special" children has resulted in a close working relationship with two local mental health clinics and various community physicians. Our school began as a cooperative school which differed from others in that we paid for assistant classroom teachers instead of initiating a parent volunteer system. The parents involved themselves in committees dealing with maintenance, baking for school parties, fund raising and contributing their special creative talents to enrich our program. After three years the school incorporated as a nonprofit, nonsectarian, educational institution according to the laws of the State of Massachusetts.

As our total enrollment grew, so the number of "special" children increased proportionately. Over the years, 120 "special" children have attended our school and most have remained with us for a two- to three-year period. We have accommodated angry, aggressive, withdrawn and nonspeaking children in addition to those children actually diagnosed as autistic, atypical or disturbed, and troubled children who defy labeling. We have accepted retarded children, perceptually handicapped youngsters, children affected with varying types of brain damage, cerebral palsy, and those with physical handicaps such as muscle disease, body deformity and hemophilia. Our "special" children, with a variety of handicaps and problems, comprise 25 to 40 percent of our total school enrollment at any time. The school interacts closely with the referring clinics and physicians, and the availability of their staffs for consultations at any time helps considerabl We keep progress records to help in pupil evaluations. Sometimes problems are

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observed in our "normal" children, and when necessary we refer these children to our source clinics. Our cooperation is mutually beneficial. The therapists and social workers visit the school periodically and we arrange to have all teachers involved with the particular child available for group conferences. The therapists, by observing in the classroom, help us to understand and identify unusual behavior of the child involved and often contribute constructive suggestions.

When we first discussed the idea of integrating "special" children into our school, we were faced with the question of how to provide adequate staffing and still maintain a tuition fee competitive with other nursery schools. Aware that parents of "normal" children would not pay more for the extras that our proposed program demanded, we decided that with a strong supervisory program, we could accept intelligent, interested women with warm and loving natures, and subsequently train them to be successful assistant teachers. Many women with the aforementioned qualities came forth from the community. Free of their personal child-raising responsibilities, and wishing to fill their empty morning hours with worthwhile activity, they have successfully involved themselves in our school program. Certainly they work not to "get rich" but to engage their time in rewarding and fulfilling experiences.

In a classroom of 17 to 24 children, we often place three to five "special" children. Each class is led by a fully accredited teacher with many years of teaching experience. The assistants, although not necessarily pretrained, enroll in state education courses and, in addition to their careful supervision, attend frequent individual and full-staff conferences. Although our pay scale is very low, ranging from $20.00 to $65.00 per week, the staff derives great satisfaction from their endeavors. Our very small teacher turnover is indicative of teacher satisfaction and devotion to their task and to the children.

As mentioned previously, "special" children may be referred to us by a clinic, hospital, physician or by the parents themselves and are registered at the school with the same procedures we use for our "normal" children. After accumulating a detailed history and reviewing test results and observations, past therapy and any other relevant or pertinent information, we call a staff conference to discuss ways of easing the child into the class. Because some teachers work better with certain types of children, we place our "special" children accordingly. We investigate source material on special problems and invite social workers and therapists to speak with us and with parents. Because this is a total school effort, all teachers are involved, even those not in the class the child will join. Each week we have regular staff meetings to discuss classroom problems and make plans for the coming weeks. True, there is a great amount of extra work involved with our type of program. Problem situations must be anticipated; extra watchings, additional conferences and planning, and unlimited patience and understanding are needed. Our teachers have accepted these extra burdens because of the tremendous satisfaction gained in seeing the children improve and become successfully integrated into the program.

After the "special" child registers, he comes to visit with his parent for a day and then enters the school full time. If a separation problem arises, we try to solve it according to the individual needs of the child. Often "special" children are overly dependent because the parents have not concentrated on developing the child's self-sufficiency. The school situation introduces the child to a new atmosphere, new rules and new goals. During the first days, the child is left

to watch and "feel his way" with no pressure from the teachers. During this time the teachers approach him with a friendly word or gesture. He is then encouraged to physically join specific group activities such as "circle time" and "snack time," although he might not verbally participate in "circle time" or eat his snack. Further participation is encouraged slowly. Most of the "special" children who have come to us have become fully integrated members of their respective classes. We have had two autistic children who have become only partially integrated. These children have had their own teachers on a one-to-one basis. They worked in the classroom as much as possible; yet, when the need arose, their own teachers would take them into another room for a change of activity.

The physical arrangement of the nursery school makes it easy to accommodate unusual situations. We have a good teacher-child ratio, not more than eight to one. There is always someone free to work with one child if necessary. We have extra rooms where children can go to "blow off steam," sit quietly or hear a story. Our many alternatives enable us to provide great flexibility. Our program runs for three hours in the morning, 9-12 noon and we arrange a midmorning snack for all children.

We have a two-day and three-day nursery program for three-year-olds, a five-day nursery program for four-year-old children, and a five-day transition class which is the equivalent of a public school kindegarten but can also be a two-year program for those children needing an extra year before first grade. Our "special" children can, therefore, attend our school for as long as four years. They are usually registered in our five-day program, giving them a total of 15 hours a week in school. This is sufficient time for "special" children to become acclimated to the school environment. Each class has children of varying ability levels, attention spans and interests, yet all children are encouraged to try new activities. The teachers offer honest praise and approval to each child; and in situations where "special" children do not perform well, there is little frustration, since standards are flexible. The children begin to feel good about themselves. In every phase the children are encouraged to do as much for themselves as possible. We try to develop their abilities to think for themselves and to instill in them feelings of security and self-assurance away from home.

Our tuition schedule for parents is $270 per year for a two-day program, $370 per year for a three-day program, and $485 per year for our five-day program. When a child comes to us who we know can only function in the group situation for short periods of time, an extra assistant is hired for that child during the period he attends school. We have one or two children yearly in this category. However, we do not refuse any child admission because of inability to pay. Thus, each year we have children on full or partial scholarships. To cover their costs, we rely on fund-raising events--art shows, raffles, auctions and outright appeals for money. By the end of the term we are usually begging, but somehow, through combined, cooperative efforts we manage to balance our accounts.

Extra Benefit for Children

By learning about our "special" children, our "normal" children also get an extra educational benefit. We make great use of the word YET, i.e., "Billy doesn't talk YET" or "Ann doesn't understand YET." This indicates that we hope the

child will eventually be able to function in the accepted manner. The experience is satisfying to the "normal" child and allows him to develop tolerance, understanding and helpfulness. This type of program encourages the "special" child since it implies our faith and confidence in his ability to develop in addition to accepting him as he is. Our "normal" children often develop the attitude of helping. If they notice a visitor watching a "special" child, they may volunteer the information that "Billy doesn't talk YET but we are helping him." Since their own security is not threatened, they do not resent the special attention given to these children, and willingly accept the fact that their friends have special needs.

We must also answer the questions from the parents of "normal" children. Some "special" children, because of appearance or behavior, are instantly noticeable. However, when parents understand the situation, they tend to be most cooperative. To attest to this fact we have never had a "normal" child withdrawn from our school.

Every month we hold a parent discussion group during school hours. These discussion groups cover a wide range of topics relating to all children, such as discipline, fears, food problems, sibling rivalry, etc. The parents of "special" children are often relieved to find that parents of "normal" children have problems similar to their own, although varying in degree and intensity. All parents gain a deeper understanding of their children and a keener insight into family relationships. We have found that the process of sharing difficulties is a great help. In addition to regularly scheduled conferences two times a year, the individual teachers and I, as director, are always available to the parents to discuss any problems. I can always be reached by telephone at home and this privilege has not been abused by our parents; indeed, I have found it very helpful in averting possible problems.

Our goals are to develop in each child a feeling of self-worth and independence. Of course we would love to see each child move into a public school situation with confidence. Even though this is not always possible, to date, we have witnessed some spectacular results. Many children who came to us with abnormal behavior patterns slowly began to imitate and adopt the normal patterns of the children who surrounded them. We have never had the problem of the "normal" children adopting the abnormal behavior of the "special" children. We have had nonspeaking children begin to speak, and children thought to be retarded prove to have normal intelligence. In some cases progress has been very slow and these children do go on to special schools. We feel that even these children benefited greatly in the areas of peer group and adult relationships, and that their experiences in our school helped them in their future adjustment to a new school environment.

Only three of the 63 children who came to us were unable to finish the school year because of the severity or intensity of their problems. Most of our children have been able to enter public schools, although they are often a year older than the children in their classes. Our follow-up calls have shown that these children adjusted to their new school situations with relative ease.

We all feel that the extra work is worth these results. Any "normal" preschool program with a well-trained staff of strongly motivated teachers willing to accept these challenges, do research on the problems they encounter, exercise patience and maintain a keen sense of humor, can institute a similar program. Surely it will help fill a great need.

Article 4

A LETTER TO MY COLLEAGUES IN EARLY CHILDHOOD EDUCATION

Charmaine Ciardi, Ed.D.
Consultant in Early Childhood/
Special Education to Resurrection
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Alexandria Virginia

Friends:

As a special educator who advocates the integration of children with developmental disabilities into cooperative preschool programs, I am frequently confronted by a stereotypic picture of the child with special needs. Somehow, society has evolved an image of the exceptional child that is at once tragic, maudlin, and pathetic. Such a conceptualization causes teachers and parents alike to shy away from including children who could contribute greatly and benefit significantly from inclusion in a well formulated early education program.

Some of the more typical concerns voiced by parents and teachers about "exceptional" children in "regular" programs are these:

1. THOSE CHILDREN ARE SO SAD. THEIR PRESENCE WOULD BE DEPRESSING TO EVERYONE ELSE.

Exceptional children are not sad; neither are they happy. They are children like all others and consequently come in a wide variety of personality types. Saying that a child is retarded describes his personality no more than saying that he is blond or black. The fact that the child learns at a slower rate is but one facet of his behavior. In addition to this, he may be curious, outgoing, shy, agile, awkward, aggressive, docile, nasty, or a joy to be near. In short, he is one of us and shares the same vast pool of human characteristics from which we all derive individuality.

The old adage that beauty is in the eye of the beholder applies equally to the child with special needs and to his "normal" peers. The sadness inherent in the label "handicapped" is a product of an adult society that would prefer not to have to deal with human differences. As adults, we have been conditioned to feel sympathy for people who do not walk, learn, see, hear, or speak as we do. Our model of the ideal person is somewhat arbitrary and on close examination, rather illogical. Shouldn't all people be accepted for what they are and can become rather than for wha they are not and will not be? Shouldn't educators be in the front line helping the rest of our society to understand this fundamental truth about the human condition?

2. WE WOULD LIKE TO HELP BUT WE DON'T HAVE THE SKILLS NECESSARY TO COPE WITH THOSE CHILDREN.

In the course of the average day, a good preschool teacher deals quite effectively with a tremendous range of developmental levels. Although she may technically teach four year old children, in truth they are not equally four years old. More likely in that group someone is an emotional toddler, others are intellectually advanced, several are slow, still others are physically immature, and someone is socially precocious. In a given child, the teacher might well be seeing several of the varying stages of development. Preschool teachers are trained to meet children at their current level of functioning and to maintain an environment in whicl growth to succeeding developmental levels can occur. That is what ALL of our childrer need.

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While it is true that some children because of the severity and the complexity of their condition require highly specialized educational programs, a far greater number need the same types of preschool experiences that "normal" children are getting. They need to go to preschool along with everyone else. Regular education versus special education! Really, do we want just "regular" education for any of our children? Wouldn't we rather that all educational experiences be very special to the children involved?

3. INCLUDING HANDICAPPED CHILDREN MIGHT DILUTE THE EXPERIENCES OFFERED TO THE NORMAL CHILDREN.

Diversity in life is stimulating. Incongruity is motivating. Allowing our children to live and to learn with children of other cultures, other races, other backgrounds is intellectually enriching. Allowing our children to learn about and adapt to children with varying developmental needs enables the child to better understand both himself and all of the other people with whom he must communicate. We know that one of the cardinal tasks of the early developmental period is the identification of self-esteem. Put simply, this involves a definition of how good am I?

In a culture such as ours that places a premium on performance, success, and competition, young children are frequently beset by a myriad of worries relating to their own acceptability. A school that says by its admission policies that all children are worthwhile demonstrates to the community as well as to all of the children enrolled that the single most important criteria by which children should be judged is their own individuality. As educators, we need to help parents and children focus on the PROCESS of learning rather than on the PRODUCTS of a school day. We know that young children need active involvement with their environment. They need to explore, create, solve problems, and imagine. They need to live in a learning situation replete with opportunities to grow in a manner consistent with their own unique self. As each child comes to know self better, he moves into a position to know others better. And so our society grows.

4. SEEING DISABLED CHILDREN WILL BE FRIGHTENING TO THE OTHER CHILDREN.

Is it harmful for young "normal" children to know a "handicapped" child? Typically, this is what happens when the two are brought together. Because curiosity is a normal part of the intellectual development of children, everyone is interested in what the braces, wheelchair, glasses, hearing aids, eye patches, or whatever are all about. This curiosity stimulates an avalanche of questions. A sensitive teacher now has the ingredients for the most meaningful discussion that she could hope to hold with her children. We know that young children are generally quite concerned about their bodies and how they work. And, nearly all children have had some experiences with family members, friends, or neighbors who have health problems. Many children are unnecessarily concerned about illness and its potential effect upon them. In curriculum construction, the preschool teacher can help the children to understand that sometimes bodies need help in the same way that cars need servicing. Some cars need new parts, snow tires and such so that they will run better. Some people need special aids to help them hear or walk better.

The deeper concern that children have relates to whether or not it will happen to them. Having laid this foundation, a teacher can now lead the children into an understanding that nearly everyone needs special help at sometime in his life and

that our world provides that help when it is needed. The recognition that a person needing extra help is acceptable and that assistance is given as needed is very reassuring to all of us. With very little help and a minimum amount of time, the "normal" children begin to discover that the "handicapped" child is really a lot more than just his disability. The children come to know all of the other things that he can do and to delight in his progress.

The most important value that we can impart to our children, the acceptance of limitations and the appreciation of strengths, flourishes in such an atmosphere. As the "normal" boy said, watching his retarded friend go down the slide, "She don't talk too good but she sure can slide!"

Growing up in our complex, aggressive, and occasionally uncivilized world is difficult for young children. They need to know a great many things in order to survive. But most of all, they need to know that each human being is valued for himself and that the ultimate goal of education is to enable each of us to become our own best and unique self.

5. WELL HE IS HERE NOW, WHAT DO I DO WITH HIM?

That is the easiest question of all to answer. Let him play, laugh, touch, explore, run, pretend, make, act, build, talk, ask, and grow. Encourage him to be, to do, and thus to learn as you would any child coming to you. Help him to be the very best that he can be. Of this you can be sure; our "handicapped" children, just like our "normal" children want to learn. With the support of a sensitive teacher and a rich environment, our children can learn together and perhaps help us to make the world a better place in which to live.

Remember this when the next "handicapped" child seeks admission to your program. The deaf and blind Helen Keller was considered to be profoundly retarded as a young child; Albert Einstein was diagnosed to be severely retarded at the age of four; Franklin D. Roosevelt, who led our country through the recovery of the Great Depression and through World War II, was a paraplegic confined to a wheelchair. Let's resolve to look at our "handicapped" children in terms of what they can do.

"We are not really all created equal. We are created equally precious and equally different. The difference is sacred .... We have the equal right to make of our individuality a thing of splendor." - Sam Levinson

Sincerely,

Charmaine L. Ciardi, Ed.D.

Post Script -

Several terms may need clarification.

"normal" what someone else told us everyone else should be
"handicapped" - what someone else decided everyone else shouldn't be
"special child" - every child I know
"special education" - a learning environment that recognizes inherent individual differences and constructs curriculum in order to effect optimal development
"regular education" - I don't know, do you?"

Article 5

"So We Do Talk About the Future":

Parent Perspectives on The Integration of Their Disabled Children Into Schools

Ellen B. Barnes*
Center on Human Policy
Syracuse, New York

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1975

*This article is basically a compilation of the statements of a number of parents who have been willing to share with us in interviews their concerns about their children's integrated schooling. They are really co-authors as well as sources of inspiration. I am grateful for their openness and responsiveness, as I am to staff members at the Center on Human Policy who conducted some of the interviews.

The recent legal assaults on the exclusion and segregation of disabled childr have come from parent activism and parent indignation about their children being penalized ("handicapped") by the schools. Children with special needs have usuall been offered no alternatives in terms of school placement. Only in recent years have so-called trainable retarded children been served in public school programs and then in segregated settings, as have been physically handicapped, deaf, blind and emotionally disturbed children.

There have always been some individual parents who have "fought" for thei child's education. But most parents were--and still are--themselves victimized by the "expert trap"; while feeling alone and at a loss to deal with their own concer about their child, they expect professionals to have the answers. They "buy" what school officials and psychologists say about their child not "fitting" or being "inappropriate" for school placement. Only when parents begin to see themselves a "experts" and assert power in the decision-making process of schools will schools offer a range of programming options of handicapped children.

Placement of Child in Integrated Setting

Some parents may find their child in an integrated setting through school decisions without any action on their part. For the majority of parents in areas where integrated programs are not the predominant way of dealing with handicapped children, placement of their child required effort, activity and sometimes threat. Often it took several years for parents to find a school program with which they felt comfortable.

Some parent comments:

> ...Through various maneuverings or fights, coupled with strokes of luck and assists from friends, Kathryn has been in school with regular kids. These have been private schools and we have paid her tuition. The teacher have often approached me with 'I really don't know much about retardation or mongoloidism.' I say to them, "Terrific!" And so we get along well. (Bennett '74, p. 10)

...The school psychologist...tested Bradley when he was 5 or 6 and, mistakenly instead of the extra copy going in the circular file...it got mailed to our house. I went through the roof because on it it said that Brad had an I.Q. of somewhere like 65 to 68 and that he was permanently excluded from the Syracuse Public Schools. They would never take him in any kind of program! That's when we sold the house and we moved out here the next year. He was at the A.R.C. for 3 years (from age 3 1/2) before he started out here at Lion Road (a regular public school).

...I wrote a letter to the head of special education asking if there were facilities and my wife and I both desired to have our son attend school in his home district, if at all possible, and we wanted a written reply as to why we couldn't if we couldn't...we found out there was no reason in the world why these boys couldn't go to Lion Road School. They had a certified teacher of the deaf, who was working as a regular teacher...He is in a class of 25 and there are 3 deaf children.

...We had him in a regular nursery school for 2 years...When he finished nursery school they had said he was ready for kindergarten and that he should go to a regular kindergarten. So we entered him...They made us think it was alright until February and they said "Sorry he can't be in this class." They said he would go into a special class, an EMR class. But they didn't have one available and that we would have to take him out of school. But we wouldn't take him out of school...They said it several times that we couldn't bring him to school and we said we were going to get a lawyer and discuss it with him...Actually there was a place in an EMR class 3 doors down from where he was. So within a week he changed into it.

As the quotations indicate, these parents have had to push to enroll their children in integrated programs. Since integration is a value that these held enough to seek out a program, it is not surprising how well their children are doing and how positive they feel about it. In several cases we are aware of pediatricians encouraging parents to seek integrated settings even though school officials were discouraging.

Benefits of Integrated School Programs

In talking with parents of handicapped children about integrated school programs they mention a number of specific values they see in the programs. These ca be summarized as covering 3 major areas:

(1) Positive changes in the child's behavior, to more self-confident and more "typical";
(2) changes in child's relationship with peers; and
(3) positive factors related to teacher attitudes and the academic program.

We all behave differently in different situations; as children particularly we learn from others how to behave in an appropriate way for that situation. Many parents described their children as imitating "normal" behavior once they entered an integrated setting.

> ...I think it (being in an integrated setting) has really stimulated her; she is more competitive. I'm not so keen on competitiveness in normal kids but I think it is important for a retarded child. I think the competitiveness stimulates her to want to be more like normal children. She mimics their behavior and she's much more independent. She won't sit back and let the family do things for her or maneuver her.

> ...Jay has become a lot more verbal...This has to do with the other children or the teachers giving him time, relating to him, and talking to him.

Many parents mention improvement in speech as one of the clearest payoffs of integrated settings.

> ...I think he became more independent...He wasn't as sheltered there...Because he could handle himself in a classroom of fifty kids, and handle himself on the playground with fifty kids, when he was home I felt I could trust him a little bit more...When he got out of that sheltered atmosphere into the classroom, he learned to trust himself and have more confidence in himself...His self-confidence and self-esteem have grown a great deal... And he makes his way very well at school; he doesn't get pushed around.

> ...When I went to school and saw him acting, you know, very ordinary, I could hardly believe it. He acted just like everyone else. He spoke clearly, he walked normally, he didn't use any mannerisms...I asked the psychiatric social worker: Why doesn't he do that at home?...He is under a lot of pressure in school and has to measure up to it, and at home he needs the resources and strengths from our family and he sort of lets down and blows off steam.

Relationships with typical peers is another clear benefit of integrated settings. And these relationships are two-way: not only do handicapped children learn from and enjoy the friendships but typical children do as well.

> ...I think these other children have learned that there's nothing to be afraid of, if a child can't hear, and that they can contribute. D.'s very outgoing and he can handle it.

> ...When the kids were in the yard playing, they all played. The neighbor kid when they played tag would run slower when Bradley was "it", so he could catch them. We know Brad is "retarded" but we've never treated him as such. He's a kid in the house and he fits in and he has his jobs and responsibilities...I think it's good for these kids to realize that brains isn't everything. They really have found out that Brad is just as good as they are. I think it will give the kids a little more compassion.

Other factors parents mention as benefits of integrated school programs include teacher attitudes ("his teachers are the most loving people and they have taken a terrific interest in him") and the academic program ("the challenge is greater; he has much more work.")

In general the group of parents with whom we spoke were active in the school their children attended. They made contact with teachers, served as roomparents. They called or visited the school frequently. In many ways the activism that gain[ed] their child's entry into integrated settings continued in terms of an interest in working with the school for their child.

Parent Concerns about Integrated School Programs

The public and parents generally describe 3 main worries about integrated school programs:

(1) attitudes of peers toward the handicapped child;
(2) attitudes of adults toward the handicapped child; and
(3) appropriateness of academic program.

The most common myth about integrated programs is that typical children will harass and bully children with disabilities. M[o]st studies indicate this is not true. In a study (Hambletown and Ziegler '73) of 2 classes of children labeled "trainable mentally retarded" in Toronto, observers tallied the kinds of interacti[ons] between retarded and non-retarded children. They found 755 positive and/or "teaching" interactions as opposed to 29 aggressive interactions; in control observations of a segregated setting of only retarded children, they found a much higher percentage of aggressive behaviors.

Of the parents we spoke with most indicated there had not been overt acts of teasing, bullying, or victimizing of which they were aware. Or if there had been problems the parents and children have dealt with them. As the parent of a deaf child said, "I guess the thing that bothers me the most is the bullies, but you are going to get them anywhere." Another parent writes:

> ...When he was at A. one of the most difficult things was walking home...He was bothered quite a lot and teased a lot...The school situation was O.K. but the walking was really hard. He got physically beaten up 3 times whi(wasn't too out of the ordinary but there was a lot of teasing. But as th(kids got to know him him there was less of that. But there was a group of kids from junior high who would pick on him all the time. I knew who they were and I used to walk with them and we used to talk with them. When you talk to them individually they were OK but as soon as they got into a group...I didn't feel I had made a mistake (about sending him to regular school) but in some areas I still felt I had to protect him...I knew how it was for me; it was a very tense situation. Just walking on th street with him, I used to get called names by these gangs.

This parent describes a teasing situation which reflects to a great extent the neighborhood in which the family lived. These experiences are, as she says, "not out of the ordinary." Nonetheless one has a feeling for the tremendous concerns all parents have if there are incidents directly affecting their child.

Janet Bennett, who is a parent of a child with Downs Syndrome, wrote an excellent article on her experiences in Exceptional Parent (May-June 1974). In it she gives us some perspective on the issues of peer victimizing. She writes:

> ...The claim 'children can be cruel' is a sacred cow. Children can be mean if it's an unequal fight, or if they feel uneasy about a situation nobody has explained to them, or sometimes because there's nothing else to do that day. Getting rid of the first two reasons sure cuts down the meanness. Even with plain cussedness, it is possible for a grownup to tell a mean kid to cut it out. Disabled kids aren't all that fragile, even though it may make you feel rotten if somebody's mean to them. 'Children can be cruel' is an insufficient reason for excluding and segregating kids. Grownups can be cruel too and segregation is one of the professionally acceptable ways. (Bennett, 1974, p. 12)

Aside from teasing and bullying, parents are concerned about the acceptance of the children by their peers and the development of friendships. As with bullying this is an issue not just for handicapped children but for all children. This acceptar may be dependent upon shared interests and experiences. A parent with a daughter who has severe physical problems says she is very worried about the growing gap between her child and her age peers. "It will never be easy for her because as sh gets older their (her classmates) skills and abilities become more obvious to her. When they reach a point which is going to happen in the next year or two where the have little in common because they have out-grown playing school or playing dolls,

then she will have a serious problem." As it happens, this child participated i. a summer program with children slightly younger than herself and had a glorious time. Perhaps the issue should not be a strict chronological grouping but the offering of a school setting which is normalizing and in which a child can participate comfortably at his/her developmental level!

A second major area parents raise about integration is the attitudes of adul toward their disabled child. They worry about adult stereotypes and expectations "that people will not allow them to function as well as they can function." School personnel insist that children with Downs Syndrome need small classes; "they seem to be unimpressed with the fact that she has been in classes of more than 20 normal children for a number of years." In general these parents felt they saw their children as more able than other adults saw them and that they wanted their children to learn independence. As one mother said, "In many ways the personal attitudes toward the retarded haven't changed; they are still the same as they were 20 years ago."

A third concern that some parents express about integrated settings is wheth or not the academic and supplemental program will be adequate. Often segregated facilities seem to offer better equipment (e.g. phonic equipment, ramps, cooking facilities) and special help, such as speech therapists, physical therapists or even just teachers with specialized training to deal with children with special needs. Other parents have concerns about the quality of the school program that any parent of a typical child might have. For example, one parent says:

> ...I have many worries and fears for my child because I don't see a very good prognosis for her physically. Her problems aren't getting easier as she is getting older; they are getting harder. She will only see more failure than successes. Unfortunately, one of the things I have been asking for which has not been one of the things the school has responded to is to build on her strengths rather than her weaknesses. We talk about it but I don't see it happening.

Other parents see real benefits to an integrated program that seem to outweigh fo them any drawbacks. One family has a profoundly deaf son who is enrolled in a r ular class in their local public school; the teacher is a certified teacher of t deaf and there are 2 other deaf children in the class. The school district pur- chased amplifying equipment for the children. The parents feel very good about program.

> ...He has people his own age, boys and girls, with whom he can associate. I think this has been very good. He has learned that he is going to have to cope in a normal hearing world; we've got him our of this cacoon, if you will, of just hard-of-hearning children...
>
> ...Do you think he is going to suffer, as time goes on, by not having specia ized help (special class or an institution)? "I don't know, it's hard to say...He's very sharp and quick. We have to take that risk, I guess. What else can we do? We don't want to send him to an institutionalized school...I think they are something that, in their time, were a necessity but I think they should be cut down...There are degrees and people have got to be made aware of the fact that all children with hearing problems don't have to go to a school for the deaf, all children with glasses don' have to go to a school to learn Braille.

A parent of a child with Downs syndrome has a similar feeling:

> ...Personally after having Bradley in the school system, I really wouldn't want him to go back into the special ed class. I think he gets far more even if he doesn't attain academically. He's getting far more in learn- ing how to get along. I mean he's not always going to be in a school. And if you keep him strictly and totally with retarded children of all severities, it will be harder on him at twenty or twenty-five.

What these parents share is a view of their handicapped child's future, as a citizen who is part of the larger community. They are trying to prepare their children for that world, even though there are risks involved. The risks are th for all parents--whether children are thought of as typical or as handicapped. I his/her own parent each child has special needs; living with each child demands parents make decisions (educational, medical, etc.) that might affect the child's future and for which there are no "right answers". These parents chose the "dig- nity of risk" for the children. As Janet Bennett (p. 11) says:

> ...People used to ask me a lot, 'what will you do with her when she gets old er?" It sometimes bothered me. Then I realized that I never really knew what I'd do with the other kids when they got older.

The basis for making decisions about an integrated or segregated school program may depend on how parents perceive the adequacy of the particular school program but most importantly how parents see their child and his/her potential:

> ...You really have to look to your child and try to help your child develop and not worry so much about yourself as parents because parents can be the biggest blocks for their children by being afraid and not letting your kids go ahead. You have to really believe in your child and be aware of how he is going along, and I think...given the chance to do as much as he can, then if he can't do it, you know it, and then you help find something he can do, so he won't lose a lot of confidence. But never underestimate him. As parents we, well, I've underestimated Ethan a lot of times, and I still do. I think it comes from the very beginning when you are told that you have a child with Downs Syndrome and that your child is going to be retarded and you don't know what you can expect really. You have to play it by ear kind of all along...Ethan once kind of said he wanted to be a doctor and help people. What he does, he does beautifully. So we do talk about the future. Originally we didn't because we didn't have any idea that he would be able to have a job. We never even thought that he would get married or any of these things, But we do discuss them now. They come up naturally. So we do talk about the future.

References

1. Bennet, J., "Proof of the Pudding", Exceptional Parent, May/June 1974, Vol. 4, #3.

2. Hambleton, D. and Zeigler, S., The Study of the Integration of Trainable Retarded Children Into a Regular Elementary School Setting, Metropolitan Toronto School Board, Toronto, Ontario. 1974.

Article 6

CHILD TO CHILD PROGRAMME

UNDERSTANDING CHILDREN WHO HAVE SPECIAL PROBLEMS

1. Group Discussion

Encourage a class or group of children to talk about children who are crippled, lame or have some special problem. Ask questions like:

-- Do you know any child who cannot walk or run or move or play like other children?

-- Why can't this child do everything the same as other children?

-- Is the child to blame?

-- How do other children treat this child? Are they kind to him? Are they mean? Do they make fun of him? Do they include him in some of their games?

-- How would you feel if you had a problem similar to this child? How would you want other children to treat you? -- To laugh at you? To pay no attention to you? To feel sorry for you? To do things with you and become your friends?

2. Games and Role Playing

Children can appreciate better the child with a special problem if they can "put themselves in his shoes." Have the children take turns acting the role of a child with different handicaps. The other children can then "act out" different ways of relating to the handicapped child: ignore him, tease him, make fun of him, help him, befriend him, include him in their games, etc. As much as possible, let the children come up with their own ideas and act them out.

Try to make the pretend handicap seem real. And remember that it is often the child with a small handicap like a limp or stiff leg who is teased more cruelly by other children than is a child with a more severe problem.

For example, to pretend one child is lame or has a stiff leg, the others can bind a pole or board to one (or each) leg so the child can't bend it.

International Year of the Child 1979

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Then have the children run a race or play tag and see how the child with the "bad leg" comes out.

After several children have played different handicapped roles, have each of them discuss his experience with the others: what it was like, what he felt, and why.

3. Including Handicapped Children in the Fun

A handicapped child cannot do everything as well as other children, but often there are some things he can do as well, or even better. Try to have the children think of examples.

For example, a child with crippled legs who has to walk with crutches, often develops very strong arms and hands.

Rather than feel sorry for a handicapped child and look only at his weakness, it is better to recognize and encourage his strengths. For example:

-- Children, try to include the handicapped child in your games and adventures. Try to let him do as much for himself as he can, and assist him only when he needs help. But remember, he cannot do everything you can. Protect him from danger.... but do not protect him too much! Too much protection is dangerous to the child's health. A child needs adventure for his mind to grow just as he needs food for his body to grow.

Many children with crippled legs can learn to swim well. Their arms become unusually strong from using crutches, and in the water they keep up easily with other children. But sometimes they have trouble getting to the water, or the other children do not think to invite them....

A friendly word of welcome to include the child with a special problem, or a little extra time or attention given him, can make a big difference -- and can make everyone feel good.

4. Children With More Severe Problems

Some children have such difficult handicaps that they cannot go swimming or play many games. But sometimes these children can learn to play marbles, cards, or guessing games.

It is especially difficult for a child who cannot speak or think as easily as other children. Such children may be very lonely. Sometimes a child who cannot speak well, or cannot speak at all, understands a lot more than people think he does. If there is such a child in your neighborhood, perhaps you children could take turns visiting him, to talk or play with him, and let him know you care.

5. Babies With Special Problems

Sometimes a baby is born with, or develops, problems that make it very hard for him to learn to sit or crawl or walk. The muscles in his back or legs may be too weak, or make jerky movements the child cannot control.

A child like this needs special help. Often there are things that older brothers and sisters can do to help the child learn to use both his mind and his body better.

For example:

If a child has trouble learning to crawl, perhaps his older brothers or sisters, or other children, can play "crawling games" with him. Two children can hold up part of the baby's weight as he tries to crawl, while another child encourages the baby to crawl by holding before him a fruit or toy. Play the game every day. As the baby grows stronger, less of his weight needs to be held up. At last he may be able to crawl alone.

There are many ways that children can help a baby or young child with a special problem learn to do new things. Here are some ideas of ways to go about it:

(1) Make it fun! If excercises can be turned into games, the child will learn faster and everyone will enjoy it more.

(2) Help the child with a problem only as much as he needs. Encourage him to do as much for himself and by himself as he can.

(3) But remember, some things are especially difficult for him. Encourage him to do a little more than he is doing now -- and then a little more. If you have him try to do too much, he may get discouraged and give up.

(4) Show the child how glad you are when he learns to do new things.

(5) Play with the child a lot in ways that help him develop not only his body, but also his mind. Talk with him and tell him stories. Carry him about. Become his friend.

A rope swing like this can help a child who is lame help himself to learn to walk -- in a way that is fun!

If there are babies or young children in your village or neighborhood who are handicapped or have special problems, perhaps the school children or other children can organize visits or take turns to play with these children and help their families.

The following forms have been developed by the PATHWAYS Project at Michigan State University. They may be of particular use to programs integrating preschool handicapped children.

Form 1

MICHIGAN STATE UNIVERSITY

COLLEGE OF HUMAN ECOLOGY
INSTITUTE FOR FAMILY AND CHILD STUDY

EAST LANSING • MICHIGAN • 48824

MSAU Day Care Center

June 1, 1978

Dear Parents:

Over the years, our early childhood centers on the MSU campus have been primarily concerned with providing quality environments and innovative programs to support young children's growth. Secondarily, the have served as training and research sites. These centers now include the MSAU Day Care Center, the Laboratory Preschool, Spartan Nursery School and the Children's Corner at the Clinical Center.

One of the new directions approved in 1974 for our centers was to expand services to children who may have special needs. Although children with special needs were occassionally enrolled prior to this time, a systematic process was initiated in 1974-75 to serve a few "handicapped" children in a pilot effort to find out what resources and adaptations were needed to adequately support teachers parents, and children in classrooms including special and regular children. We found through these experiences that the inclusion of special children has had some surprising benefits for all of us. Children and staff alike have grown in appreciation of the unique qualities of individuals. Special children have responded positively to the stimulation and support received. The staff has learned that often only minor adaptation in planning and procedures is required to successfully include a "handicapped" child in a classroom, and when additional staff or resources are required, these services can be used to enhance the enviornment for all. The benefits of having special children have been so profound that in May of 1977, the Children's Board at MSAU lent support by revising the Center's admission policies to include placement of children with special needs.

These early efforts also developed into a more formal program, the PATHWAYS Project, supported in part by federal funds (Bureau for Education of the Handicapped) and intended as a demonstration project. The PATHWAYS Project was initiated in the fall of 1976 as a three-year demonstration effort to provide support services to teachers, parents, and all children in our regular classrooms, including those with special needs. One objective of the project is to document and evaluate the entire process of integrating special children into established early childhood programs. The resulting information and guidelines will hopefully help other early childhood centers and educational agencies better understand the advantages and possible disadvantages of "mainstreaming" in the early years.

Beginning in the fall of 1977, increasing numbers of classrooms on- and off-campus will be involved in the project. What this means to you as a parent is that

1) The day care program, as it has existed, will basically continue unchanged with the possibility that greater resources will be made available to all participants.

2) Any classroom in our day care center may become a demonstration classroom *if a match between the needs of the teaching staff, children and parents is compatible with the enrollment of a child with special needs.* 201

3) If a classroom is identified as a demonstration classroom, some additional observations and assessment processes will be incorporated into the program and parents may be requested to share their observations and personal feelings about their own and their child's participation in the program. This will aid in evaluating the impact of the program on participants.

4) Having a special child in the classroom may or may not generate questions from children. For instance, *"Why does he wear those things (hearing aids) in his ears?"* or *"Why doesn't she talk?"* Parents may need to help their children deal with these questions as well as problems of relating to others who may sometimes be seen as "different".

5) To satisfy the requirements of having a federally funded demonstration project, certain regulations must be followed. One of these is that written parental consent is required to insure that parents are informed about the project and approve of the methods used to gather and disseminate information about children's interactions and development. Another need is for visuals to describe the program to other interested parties, thus a media release is requested. Although this is a generalized release form, parents will be notified prior to each specific instance in which pictures or videotapes are taken in their child's room.

The immediate benefits of having the federally funded project are that:

1) more systematic observations and assessments can be made about the impact of the program on children, teachers, amilies and the community

2) greater numbers of resources can be made available to all children in the form of staff training, consultants, and special equipment and materials

3) parents, students, and staff will gain experience in meeting individual needs of children to enhance their ability to work effectively with a greater diversity of children's needs in the future

But more importantly,

4) an atmosphere of acceptance and support can be fostered for greater numbers of families who want to have an integrated environment as an alternative for their child during the preschool years

We are proud to participate in this commitment to better serve all children by serving those with perhaps "greater" needs. We hope that you will also support this commitment. Your cooperation is most important for the success of the effort.

Please read the enclosed materials and if you agree to participate in the demonstration project, sign and return the parental consent and media release forms. The Day Care Center or project staff would be most willing to answer any questions you may have about the project. Contacts can be made by calling: 353-5154 or 353-7999. Please return the enclosed forms by mail or drop them off at the Day Care Center office prior to June 12, 1978.

Sincerely,

Suzanne Sullivan
Program Coordinator, MSAU Day Care Center

Nancy Carlson
Assistant Director, Institute for Family and Child Study

ATHWAYS

TEACHER DEVELOPMENT CHECKLIST:* A Self-Assessment Tool for Early Childhood Educators Who Integrate "Special" and "Typical" Children in Their Classrooms

This instrument is designed to gather general information about teacher development, based on teachers' own perceptions of their skills and growth. This Checklist is a part of the PATHWAYS Project Evaluation Process to document the impacts of participation in the PATHWAYS model on integrating teachers. Drawing on the knowledge and experience of numerous teachers, coordinators and consultants, the Checklist also represents a description of key domains of teacher competency relevant to the developmentally integrated early childhood classroom.

DIRECTIONS: Please read through this instrument and use the rating scales to evaluate yourself on two levels: your current level of skill and the extent to which you have grown in this area during the last year. Only rate your current performance and degree of growth for the items in italics. The capitalized headings represent larger domains or categories of teacher development.

	Present Level of Performance			Degree of Growth		
	Definite Strength	Adequate	Needs Improvement	A Lot	A Little	No Change
I. ABILITY TO RECOGNIZE AND ACQUIRE INFORMATION ABOUT SPECIAL NEEDS OF YOUNG CHILDREN						
A. Exhibits knowledge of typical development						
1. Able to recognize developmental themes which underlie children's behavior and apply that information to program decisions.						
2. Able to articulate and implement classroom management techniques based on child development principles.						
3. Implements a program based on developmental needs of children in the group, as discovered through observation and assessment.						
B. Recognizes children experiencing developmental problems (at-risk)						
1. Aware of special, temporary and long-term needs of young children						
2. Able to evaluate and recognize the signs of physical and emotional distress in young children						
C. Seeks and uses information about specific handicapping conditions						
1. Has knowledge of characteristics and needs of children in own classroom who experience handicaps						
2. Knows about different ways of working with "handicapped" child(ren) enrolled in the program						
II. INTERACTIONS WITH CHILDREN						
A. Interacts with children to manage and direct/redirect behavior						
1. Able to respond to the context, motivation and meaning of children's behavior using well timed interventions						
2. Sets reasonable limits at the level of complexity that is compatible with child's level of understanding and ability						
3. Uses positive, clear directions when redirecting and guiding behavior						

	Present Level of Performance			Degree of Growth		
	Definite Strength	Functional	Less Than Adequate	A Lot	A Little	No Change
B. Interacts with children to facilitate affective expression and positive self-concept						
1. *Acknowledges children's feeling and encourages expression without necessarily agreeing with them*						
2. *Expresses physical warmth and positive responses (smiles, embraces) as an integral part of child/teacher interaction*						
3. *Divides attention and staff amongst all children in the class so that each child receives some individual attention and personal contact*						
4. *Relates to handicapped children with an attitude of acceptance and "matter-of-factness" as opposed to one of rejection or over-attentivness*						
C. Interacts with children to facilitate language acquisition and communication skills						
1. *Communicates with chidlren using simple, direct language to describe, model and extend their understanding and verbalizations*						
2. *Capitalizes on experiences, songs, finger plays to encourage verbal communication*						
3. *Uses a variety of communication modes (verbal, non-verbal, concrete)*						
4. *Listens to children*						
D. Interacts with children to enhance cognitive development						
1. *Knows and uses different ways to extend play to increase its "learning" potential*						
2. *Breaks down tasks to child's level of ability and sequences learning activities appropriate to child's age and stage of development*						
3. *Uses questioning and inquiry skills to foster learning through discovery, problem solving and association*						
E. Interacts with children to facilitate social interaction						
1. *Fosters social interaction by creating many opportunities for children to learn and play together in various sized groups*						
2. *Helps children work in groups by establishing motivating environments and reasonable limits*						
3. *Models and guides children's interactions and responses to encourage interchange between children*						
4. *Prepares children within the regular classroom for the entry of special children into the class, as appropriate*						
F. Interacts with children to facilitate motor development						
1. *Provides a variety of activities and materials which enhance eye-hand coordination, small and large muscle development and perceptual motor development*						
2. *Sequences motor activities developmentally to provide a progression of experiences over time*						
3. *Can break down motor tasks into smaller components for children who have difficulty*						

	Present Level of Performance			Degree of Growth		
	Definite Strength	Adequate	Needs Improvement	A Lot	A Little	No Change
III. PLANNING/DESIGNING						
A. Plans and designs appropriate educational experiences for groups of children						
1. Provides materials and experiences which utilize the senses of vision, touch, hearing, smell and taste						
2. Able to create learning experiences which build on children's existing and developing modes of learning						
3. Uses a variety of teaching approaches: modeling, direct instructions, one-to-one, group presentation, child-to-child						
4. Balances child initiated and adult initiated activities						
B. Plans program to meet individual needs						
1. Provides for and manages diversity in affective domain: cooperative/compliant children; apathetic/withdrawn children; angry/defiant children						
2. Provides for and manages diversity in cognitive domain for children who seem: very bright or gifted; bright; average; slow; delayed.						
3. Provides for and manages diversity in psychomotor domain for children who are: without sensory deficits or handicaps and exhibit good gross and fine motor control; blind; deaf; orthopedically disabled; epileptic; cerebral palsied; have undiagnosed problems; have multiple characteristics						
4. Adapts regular materials, curriculum and physical environment to meet the needs of children with different abilities						
C. Adjusts plans to respond to changing conditions (flexibility)						
1. Alters own behavior to adjust interventions so that they related directly to child and situation						
2. Implements a systematic planned structure while remaining open to change as needed						
IV. MANAGEMENT OF THE ENVIRONMENT						
A. Manages physical and human resources						
1. Divides room into distinct, visible work areas which provide for active, quiet, manipulative, imaginative, sensory areas and which facilitate flow of movement in room						
2. Designs, arranges and supervises ongoing placement of materials for bulletin boards and visual displays at children's level and within kids' interest						
3. Able to provide a physically and psychologically safe environment						
4. Plans for appropriate, adult supervision of children and activities, utilizing individual strengths of adults						
B. Manages the flow of activities, time and attention						
1. Able to maintain a perspective of the whole classroom at one time, attending to peripheral and focal activities						

	Present Level of Performance			Degree of Growth		
	Definite Strength	Adequate	Needs Improvement	A Lot	A Little	No Change
2. *Develops and maintains consistent routines with time periods that are labelled for children, provides smooth and effective transitions*						
V. ASSESSMENT						
A. Observes and records behavior/characteristics of children						
1. *Able to observe a child's behavior and adequately describe the important aspects of the behavior and the setting*						
2. *Able to recognize or assess individual children's developmental abilities/needs using assessment instruments*						
3. *Develops a system for recording student progress*						
B. Interprets assessments and applies that knowledge to plan and manage the environment						
1. *Able to interpret assessment information to determine needs and appropriate activities for individual children*						
2. *Evolves anecdotal records, behavioral descriptions or progress reports which may be used to determine further programming for the child in the mainstream classroom*						
3. *Regards achievement in terms of child's progress rather than normative standards of the group*						
VI. PERSONAL AND PROFESSIONAL QUALITIES						
A. Recognizes own abilities and needs						
1. *Able to maintain a balanced perspective about self when examining own limitations, attitudes and needs*						
2. *Able to be self-critical, in touch with own feelings and capable of monitoring own behavior*						
3. *Balances own intimate, personal needs with professional responsibilities and seeks appropriate support to deal with issues of extreme cognitive and emotional impact*						
B. Conducts self in a professional manner						
1. *Is aware of and implements responsibilities, expectations and ethical practices related to working with young children (confidentiality, maturity, cleanliness, cooperation*						
2. *Able to communicate effectively and sensitively with individual children, groups of children, parents, other staff, consultant and support personnel from other agencies and disciplines*						
3. *Exhibits warmth, acceptance and sensitivity towards others, including those who are different from personal norm, without allowing stereotypes or prejudices to interfere*						

	Present Level of Performance			Degree of Growth		
	Definite Strength	Functional	Less Than Adequate	A Lot	A Little	No Change
VII. INTERACTIONS WITH FAMILIES						
A. Develops and maintains rapport with parents						
1. Relates to parents in a relaxed and responsive way, fostering a team approach						
2. Maintains periodic communication with parents to discuss child's needs and growth; can express and hear concerns and suggest positive alternatives (including referral to community services						
B. Involves families with program						
1. Communicates about and involves parents with program activities, interprets assessment findings and educational plans to parents						
2. Knows of and uses various methods of parent involvement to meet individual needs (guided observation, classroom participation, planned meeting, group discussions)						
C. Assists families in interactions with community services and agencies						
1. Identifies and shares information about community resources for support, equipment, information, funding - helps parents clarify own needs for services						
2. Able to be tactfully assertive with other professionals in advocating for children and families						
VIII. INTERACTIONS WITH STAFF AND COLLEAGUES						
A. Develops and maintains working relationships						
1. Includes all adults in planning and implementing classroom and child goals						
2. Provides appropriate support and preparation to other adults in classroom by clarifying their roles and responsibilities						
3. Keeps other people in program informed of decisions, changes and new developments regarding individual children and total classroom; seeks variety of inputs in decision making						
4. Shares relevant information with adults about individual children's special needs so that all adults in classroom can interact appropriately with children						
B. Responds sensitively to individual differences of adults						
1. Shares information at a level appropriate to each adult's knowledge, skills and experiences						
2. Incorporates uniqueness and special abilities of other staff members into total program, considers individual strengths and needs when planning						
3. Provides adult staff members with support and relief as needed, aware of individual tolerances and "breaking points"						
C. Stimulates professional development						
1. Makes available resource materials and experiences in support of continued learning by adult participants in classroom						

	Present Level of Performance			Degree of Growth	
	Definite Strength	Functional	Less Than Adequate	A Lot / A Little	No Change
2. *Models openness to change, integration and sharing of new ideas*					
3. *Seeks out new learning experiences for self, attends workshops and conferences, reads current literature, uses resource and consultant personnel to expand own competencies*					
IX. SOCIAL/POLITICAL AWARENESS					
A. Is knowledgeable of laws and issues affecting young children and their families					
1. *Can articulate and comply with requirements of PL 94-142 (Federal-All Handicapped Children's Education Act)*					
2. *Can articulate to persons outside the field the rationale for Early Intervention and integrated early childhood experiences*					
3. *Aware of the implications of labelling children with special needs*					
B. Communicates about programs and issues					
1. *Speaks out on behalf of young handicapped children and their families in public forums and in individual encounters to positively influence public opinion*					
2. *Able to present a summary of handicapped child's experiences in own program for an EPPC meeting*					

*Experimental Instrument developed at the Institute for Family and Child Study for the PATHWAYS Project, Michigan State University, September 1977.

Form 3

Integration Opinionnaire*

The following statements reflect various opinions and beliefs that individuals hold toward "integration" or the placement of handicapped children in educational programs for typical children. When responding to these statements, note that the terms "integration" and "mainstreaming" are used synonymously. Likewise, the terms "special" and "handicapped" are meant to be interchangeable and represent a variety of handicapping or developmentally delayed conditions. Unless otherwise stated, please respond to the statements in the context of early education (birth through age six). Circle the response that best represents your opinion about the statement.

(Response key: Strongly Agree (SA), Agree (A), Disagree (D), Strongly Disagree (SD), Undecided (U), NOTE: Please use the response category "Undecided" only if you truly have no opinion about the statement.)

1.	A primary benefit of mainstreaming in early childhood is the opportunity it offers for typical children to learn how to interact with children of different skills and abilities.	SA A D SD U
2.	A handicapped child in a regular preschool program requires more adult attention than typical children require.	SA A D SD U
3.	Handicapped children disrupt the classroom and serve as undesirable models for typical children.	SA A D SD U

*Experimental instrument developed at the Institute for Family and Child Study, Michigan State University for the PATHWAYS Project, September 1978.

(continued on next page)

[Response key: Strongly Agree (SA), Agree (A), Disagree (D), Strongly Disagree (SD), Undecided (U). NOTE: Please use the response category "Undecided" only if you truly have no opinion about the statement.]

4.	When only one or two handicapped children are present in a regular program, they often become isolated.	SA A D SD U
5.	With supplemental services, the regular preschool program can provide the environment and modeling that stimulates a handicapped child's learning.	SA A D SD U
6.	A disadvantage of mainstreaming is that it may be frustrating for a handicapped child to see other children doing things that (s)he may not be able to do.	SA A D SD U
7.	The attention and individualized help that special children get in segregated programs for the handicapped outweighs the value of the interaction with typical children in integrated settings.	SA A D SD U
8.	The specialized instruction that handicapped children need cannot effectively be provided by regular preschool and nursery school teachers.	SA A D SD U
9.	It may be an advantage for parents of handicapped children to be involved with typical children so that they can keep a balanced perspective on what to expect in children's behavior.	SA A D SD U
10.	It is reinforcing and rewarding for parents of handicapped children to feel that their child is accepted and capable of functioning in a regular classroom.	SA A D SD U
11.	An integrated preschool experience for a handicapped child may help stimulate social and language development, but isn't structured enough to provide a total educational experience.	SA A D SD U
12.	"The least restrictive environment" is one in which the handicapped child is treated as much like a typical child as possible.	SA A D SD U
13.	Handicapped children require almost constant one-on-one attention from a teacher in order to achieve their individualized learning objective.	SA A D SD U
14.	Handicapped children can be best served by professionals specially trained to teach the handicapped.	SA A D SD U
15.	Most regular teachers are not able to handle a whole classroom of typical kids as well as the demands of one or two children with special needs.	SA A D SD U
16.	Regular teachers experienced in working with handicapped children are better able to recognize the needs of typical children.	SA A D SD U
17.	Mainstreaming provides an opportunity for typical children to realize that handicapped children have feelings and thoughts just like they do.	SA A D SD U

[Response key: Strongly Agree (SA), Agree (A), Disagree (D), Strongly Disagree (SD), Undecided (U). NOTE: Please use the response category "Undecided" only if you truly have no opinion about the statement.]

18.	Since many young, handicapped children need care during the day in addition to special educational experiences, financial and professional assistance must be made available to family and center day care providers.	SA	A	D	SD	U
19.	The public schools should provide the resources and professional services so that young handicapped children have a variety of alternative educational environments available for them.	SA	A	D	SD	U
20.	Many young handicapped children could benefit from placement in both specialized environments and integrated environments to maximize growth in all areas of development.	SA	A	D	SD	U
21.	Only mildly and moderately handicapped children should be placed in programs with typical children.	SA	A	D	SD	U
22.	A good way to enhance people's attitudes toward the handicapped is to have children make contact with the handicapped in natural, matter-of-fact ways while they are still young.	SA	A	D	SD	U
23.	Adult biases, stereotypes and underestimations of special children's abilities are more likely to occur in segregated than integrated settings.	SA	A	D	SD	U
24.	Handicapped children are more likely to grow in independence and confidence in a segregated rather than integrated setting.	SA	A	D	SD	U
25.	Parents who wish to have their special child enrolled in regular preschool programs should receive the same services and financial support for their child's education as parents who enroll their child in programs for special children only.	SA	A	D	SD	U
26.	Most communities are doing a good job of including handicapped children in educational and recreational programs designed for typical children.	SA	A	D	SD	U
27.	Cooperation between community agencies is not necessary in order to effectively meet the needs of special children.	SA	A	D	SD	U
28.	Each handicapped child needs an individually designed program.	SA	A	D	SD	U
29.	Parents of handicapped children would rather have their children placed in special classrooms than risk potential unpleasant experiences in classes for typical children.	SA	A	D	SD	U
30.	Efforts to mainstream handicapped children during the preschool years are at least as important as mainstreaming during the elementary school years.	SA	A	D	SD	U

Form 4 Classroom Socio-Observation

The classroom socio-observational technique was developed to assess the social involvement and play activity of children in the classroom setting. It was developed by Jo Lynn Cunningham and Tito Reyes, Family and Child Study Center, Michigan State University.[1,2] The present procedures are an adaptation of the original instrument.[3]

General Procedures

Three observations are made each day during the regular class session. Children should be involved in indoor free choice play activities at the time of the observations. Observations should begin approximately ten minutes after the play period has begun to allow time for children to become involved. All of the children in the classroom should be accounted for before starting. Check with the head teacher or student teacher to note absentees and locations of children not present in the classroom. Do not proceed if the target child is not present.

Name tags or a number or letter code should be placed on each child (taped or pinned) prior to the observation. If only a few children have no name tag, you may identify them by dress; writing a description by thier name on the recording form. Such tags or descriptive notes will aid the observer in identifying the children quickly.

The setting for the observation will be the classroom that includes a variety of activities for free play (blocks, house corner, manipulative toys, etc.) The regular teachers will be present in the room, and their interactionswith children should be recorded.

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[1]Cunningham, J.L., and Reyes, R.F. The sociometry of preschool children Unpublished paper, Michigan State University, 1969.

[2]Special thanks are given to Kristin Anderson for her help with the preliminary testing of this technique.

[3]The present adapted version was developed by Mary Andrews, Institute for Family and Child Study, Michigan State University, 1973.

Form

The form used for recoridng observations is a drawing of the floor plan of preschool classroom(s) with major play areas indicated. It is suggested that a list of all children in the class with their identifying code letters be attached. Since a set of three consecutive observations will be made, identify each observation by number (1, 2, 3).

Recording Observations

For each observation, a systematic recording is made of the play location and involvement of each child. Start at one end of the room and record each individual as quickly as possible.

Each child must be recorded once and only once. Therefore, if a child moves to another group after an observation is recorded of his activity, he is NOT recorded again, even though the other children in the new group ARE recorded if they have not been previously observed.

As soon as the entire class has been recorded and checked to be sure all children are recorded only once, proceed with the second and then third in the set of three consecutive observations.

Codes

The recording of each item is as follows:

AREA

Major activity areas are indicated on the observation form.

INDIVIDUAL

A...N = Subject (unique identifying letters are assigned to each child)

X = Teacher

Y = Other Adult

PLAY INVOLVEMENT

1 = Unoccupied behavior: The child apparently is not playing at all, at least not in the usual sense, but occupies himself with watching anything which happens to be of momentary interest. When there is nothing exciting taking place, he plays with his own body, gets on and off chairs, just stands around, follows the teacher, or sits in one spot glancing around the room.

Codes

PLAY INVOLVEMENT

2 = Solitary Play: The child plays alone and independently with toys that are different from those used by the children within speaking distance and makes no effort to get close to or speak to the other children. His interest is centered upon his own activity, and he pursues it without reference to what others are doing.

3 = Onlooker Behavior: The child spends most of his time watching the others play. He often talks to the playing children, asks questions, or gives suggestions, but does not enter into the play himself. He stands or sits within speaking distance of the group so he can see and hear all that is taking place. Thus, he differs from the unoccupied child, who notices anything that happens to be exciting and is not especially interested in groups of children.

4 = Parallel Play: The child plays independently, but the activity he chooses naturally brings him among other children. He plays with toys which are like those which the children around him are using, but he plays with toys as he sees fit, without trying to influence the activity of the children near him. Thus, he plays beside, rather than with, other children. This activity is characterized by physical proximity and similarity of activity with reference to other children.

5 = Associative Play: The child plays with other children. They may be borrowing and lending play materials or following one another with trains and wagons. There are mild attempts to control which children may or may not play in the group. All engage in similar, if not identical, activity. There is no division of labor and no organization of activity. Each child acts as he wishes and does not subordinate his interest to the group. There is interaction between children, but no common goal.

6 = Cooperative Play: The child plays within a group that is organized for the purpose of making some material project, of striving to attain some competitive goal, of dramatizing situations of adult or group life, or of playing formal games. There is a marked sense of belonging or not belonging to the group. The control of the group sitiuation is in the hands of one or two members who direct the activity of others. The goal and the method of attaining it necessitate a division of labor, the taking of different roles by various group members, and the organization of activity so that the efforts of one child are supplemented by those of another. The critical distinction is the goal-directedness of the group.

Direction of Interaction

Small arrows (→) should be placed on the recording form to indicate to whom children are interacting when at a five or six level of play. If three or more children are all interacting equally, circle the group instead of placing arrows. If some children are at one level of play and others at another level,

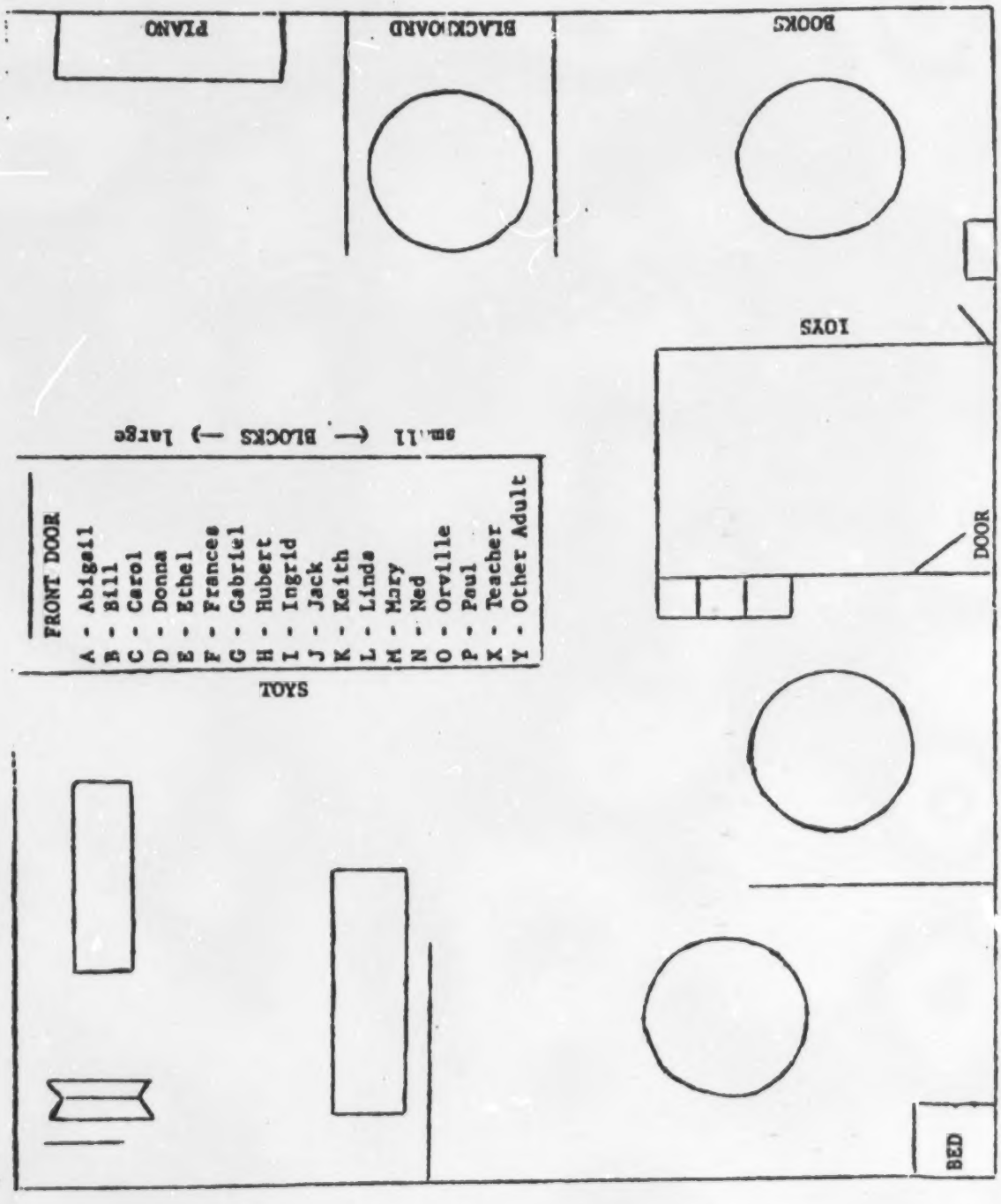
place arrows to indicate direct interaction and also circle the group to identify a common activity.

Child-to-teacher interactions should also have arrows attached to indicate the direction of the initiation. If no single direction is apparent, draw two-headed arrows. (direction can be determined by who asks questions, gives directions, or gives information, etc.)

CLASSROOM SOCIO-OBSERVATION

Class_____ Date_____

Observer_____ Time_____



Example of Floor Plan

Form 5

CHILDREN'S BEHAVIOR CHECKLIST*

Name of Child_____ Age_____ Date_____

Name of person filling out checklist_____

Relationship to child (mother, father, teacher)_____

Your responses to the following checklist will help us learn more about your child to help in planning for his (her) educational program. The following is a list of items describing many aspects of children's behavior...things that children do or ways they have been described by others. Not all of the items will apply to the particular child you are describing. For instance, many two year olds cannot go to the toilet by themselves and most three year olds can't button garments.

First, please place a check mark (✓) in the first column by each item that accurately describes your child or is typical of your child's behavior. Secondly, after you have gone through the list, please go back through the items and place a check mark (✓) in the second column by those behaviors that are present or *should be* present and are concerns for you. These would be behaviors that you feel need attention. (Ex. frequent colds may characterize your child's health, and this is a concern to the family).

	Does this apply?	Is this a concern?
1. Is happy when he (she) has done a good job.	_____	_____
2. Is concerned about feelings of others.	_____	_____
3. Demands excessive attention.	_____	_____
4. Can't wait - must have things immediately.	_____	_____
5. Gets irritated or angry easily.	_____	_____
6. Is restless, overactive.	_____	_____
7. Has short attention span, unable to concentrate.	_____	_____
8. Seems slow to learn.	_____	_____
9. Is a finicky eater.	_____	_____
10. Plays with toys in a rough way.	_____	_____
11. Hurts self when angry.	_____	_____
12. Is able to communicate needs, problems non-verbally.	_____	_____
13. Is able to communicate needs, problems verbally.	_____	_____
14. Avoids eye contact.	_____	_____

*Experimental instrument developed at the Institute for Family and Child Study for the PATHWAYS Project, Michigan State University, September 1977.

		Does this apply?	Is this a concern?
15.	Is jealous or possessive.	_____	_____
16.	Seems slow to warm up to strangers.	_____	_____
17.	Has frequent colds.	_____	_____
18.	Wheezes and coughs a lot.	_____	_____
19.	Responds to praise.	_____	_____
20.	Looks awkward or clumsy when walking.	_____	_____
21.	Doesn't pay much attention to others; seems more involved with self.	_____	_____
22.	Has trouble falling asleep at night.	_____	_____
23.	Seems to have difficulty hearing.	_____	_____
24.	Seems to have difficulty seeing.	_____	_____
25.	Needs constant attention; unaware of safety factors.	_____	_____
26.	Can communicate toileting needs "in time".	_____	_____
27.	Can go to toilet by self.	_____	_____
28.	Can wash and dry hands alone.	_____	_____
29.	Brushes his (her) teeth alone.	_____	_____
30.	Can undress self.	_____	_____
31.	Can button.	_____	_____
32.	Can put on shoes/boots (not tying)	_____	_____
33.	Can stay dry at night or during nap.	_____	_____
34.	Eats with spoon and fork.	_____	_____
35.	Pours own drink.	_____	_____
36.	Controls spills.	_____	_____
37.	Rebels when routines are upset.	_____	_____
38.	Handles small objects skillfully.	_____	_____
39.	Memory seems poor; forgets things that have just happened.	_____	_____
40.	Seldom laughs or smiles.	_____	_____

		Does this apply?	Is this a concern?
41.	Is left out of things and ignored by others.	_____	_____
42.	Has short periods of loss of contact; "blank spells"	_____	_____
43.	Asks for help on tasks unnecessarily.	_____	_____
44.	Doesn't start a conversation or initiate to others; others must approach him (her)	_____	_____
45.	Takes things apart frequently.	_____	_____
46.	Shows pride in accomplishments.	_____	_____
47.	Cries for no apparent reason.	_____	_____
48.	Seems comfortable in new situations.	_____	_____
49.	Spends most of time sitting and watching; doesn't play or do things with others.	_____	_____
50.	Gets carried away with his (her) feelings; acts on them right away.	_____	_____
51.	Is fearful of some playground equipment.	_____	_____
52.	Feelings are easily hurt.	_____	_____
53.	Talks in a way that seems different; "baby talk"	_____	_____
54.	Asks the same question over and over.	_____	_____
55.	Makes friends quickly and easily.	_____	_____
56.	Lacks pep and complains of being tired.	_____	_____
57.	Sucks thumb.	_____	_____
58.	Very moody - sad one minute and happy the next.	_____	_____
59.	Has a strong attachment to a person or object.	_____	_____
60.	Has unusual craving for a food.	_____	_____
61.	Refuses to share things with others.	_____	_____
62.	Is frightened of being alone.	_____	_____
63.	Avoids talking about himself (herself)	_____	_____
64.	Has uncontrollable outbursts of temper.	_____	_____
65.	Able to stand up for own rights.	_____	_____

	Does this apply?	Is this a concern?
66. Play is aimless; doesn't seem to make or accomplish anything.	_____	_____
67. Is unusually curious about things.	_____	_____
68. Aggressive and overpowering with other children.	_____	_____
69. Affectionate - enjoys being physically close to others.	_____	_____
70. Shows appreciation when others help or do things for him (her).	_____	_____

Thank you for your cooperation. If there are other behaviors or conditions that you are concerned with or want to bring to our attention, please comment below. Your response will be kept confidential.

COMMENTS:

Form 6

Individualized Educational Plan*

Child's Name _____ Initial Plan Date _____

B/D _____ Review Dates: _____ _____ _____

Committee - Person Responsible for Initiating Review _____

Goals:

Motor:

Fine Motor:

Cognitive:

Language:

Self-Help:

Social:

Parent Signatures: _____

* Experimental Instrument developed at the Institute for Family and Child Study for the PATHWAYS Project, Michigan State University, September 1977.

Goal:

Objectives:

Strategies:

Goal:

Objectives:

Strategies:

Form 7

ANECDOTAL RECORDS *

Child_____ Recorder_____ Date_____ Setting_____

TIME	EVENTS	COMMENTS

*Experimental Instrument developed at the Institute for Family and Child Study for the PATHWAYS Project, MIchigan State University, September 1977.